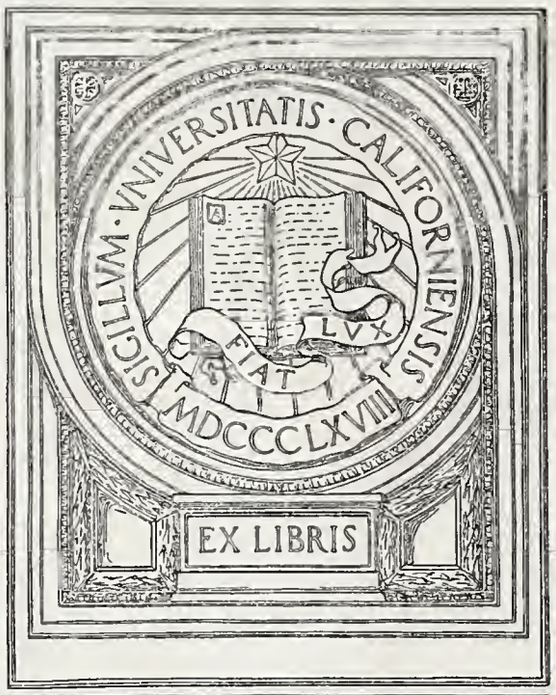
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Index—California and Western Medicine, Volume 42
January to June, 1935

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I. Authors.
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Or.—Original article.
C. R.—Case Report.
B. M.—Bedside Medicine.
E. C.—Editorial Comment.
C. N.—Clinical Notes.
L. M. H.—Lure of Medical History.

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BOOK REVIEWS

(Continued from Page 11)

patient, and to the growth of hospitals and nursing. The concluding chapters tell the story of the amazing strides which this country has made in preventive medicine and in the more highly scientific aspects of medical knowledge. There is a comprehensive bibliography and two indexes, one of persons and one of subjects.

Recommended for the physician's book shelf and library table.

A Manual of the Practice of Medicine Prepared Especially for Students. By A. A. Stevens. Thirteenth edition. Pp. 685. Illustrated. Philadelphia and London, W. B. Saunders Company, 1934. Price, $3.50.

There are few omissions in this brief presentation of the essentials of medical practice. Gallop rhythm, that important auscultatory sign of heart failure, is ignored, and no notice occurs in regard to the use of quinidin.

In general, recent therapeutic and diagnostic measures of proved value are correctly given, although in many instances the prescriptions recommended seem too elaborate. The use of silver nitrate for peptic ulcer and for gastric hypersecretion is still sanctioned. If tabloid treatment for medical students is considered necessary, this text may be presented. W. D.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 72)

From an article on "The Use of Nitrous Oxid and Oxygen to Maintain Anesthesia and Positive Pressure for Thoracic Surgery" by Sterling Bunnell, M.D., San Francisco.

In presenting the following, no claim is yet made for its practical value, and until it has been worked out more fully it must rest merely as a suggestion.

Physiologically, positive and negative pressure apparatuses are equally satisfactory for allowing respiration to continue when the chest is open, but the positive pressure apparatus has the advantage of simplicity and portability. Nitrous oxid with oxygen has some decided advantages over ether as an anesthetic for this work, and moreover eliminates the necessity of a pump. . . .

From an article on "Enucleation of the Tonsil in Its Bearing on General Infections" by Redmond Payne, M.D., San Francisco.

I am writing this brief paper upon the subject of general infection through the tonsil and the necessity for the radical tonsil operation, because we must hear it repeated to us and impressed upon us many times before its importance is brought home to us; also because in many of our large cities today it is still an exception to find an operator who is doing the complete radical enucleation.

There is no more reason for doing an incomplete tonsil operation than imperfectly performing any surgical operation. . . .

From an article on "Report and Presentation of Specimens of a Case of Central Cavity Formation in the Spinal Cord Due to Trauma Without Fracture or Dislocation of the Vertebral Column" by Edward T. Dillon, M.D., Los Angeles.

While severe injuries to the vertebral column may take place without injury to the spinal cord, on the other hand serious lesions of the cord may be found without discoverable fracture or dislocation of the bones. . . .

From an article on "Comments on Tropical Medicine" by Creighton Wellman, M.D., Oakland.

It is significant to compare the apathy, and even aversion, which advocates of the study of tropical disease had to contend with a few years ago with the interest which is now evinced in this subject from all quarters. The close relation of tropical medicine to general medicine, the valuable research which has

(Continued on Page 16)

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Call him by what name you will—Leatherstocking—Daniel Boone—or just The Pioneer, he stands in the history of the nation as The Builder. He forged the trail! He fought the fight! Blindly and against uncounted odds, he built the West—the West which was the foundation of the new United States.

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American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

Clinical Laboratory of Drs. W. V. Brem, A. H. Zeiler, Roy W. Hammack and G. D. Maner, 657 So. Westlake Avenue, Los Angeles, California.

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Physicist

TWENTY-FIVE YEARS AGO

(Continued from Text Page 14)

been done in the tropics, much of which throws light on medical problems at home, and the constant introduction of tropical affections into our own country have all aided in increasing this interest. . . .

San Joaquin County—"The Osteopaths: How Shall We Treat Them?" by George H. Aiken, M.D., Fresno.

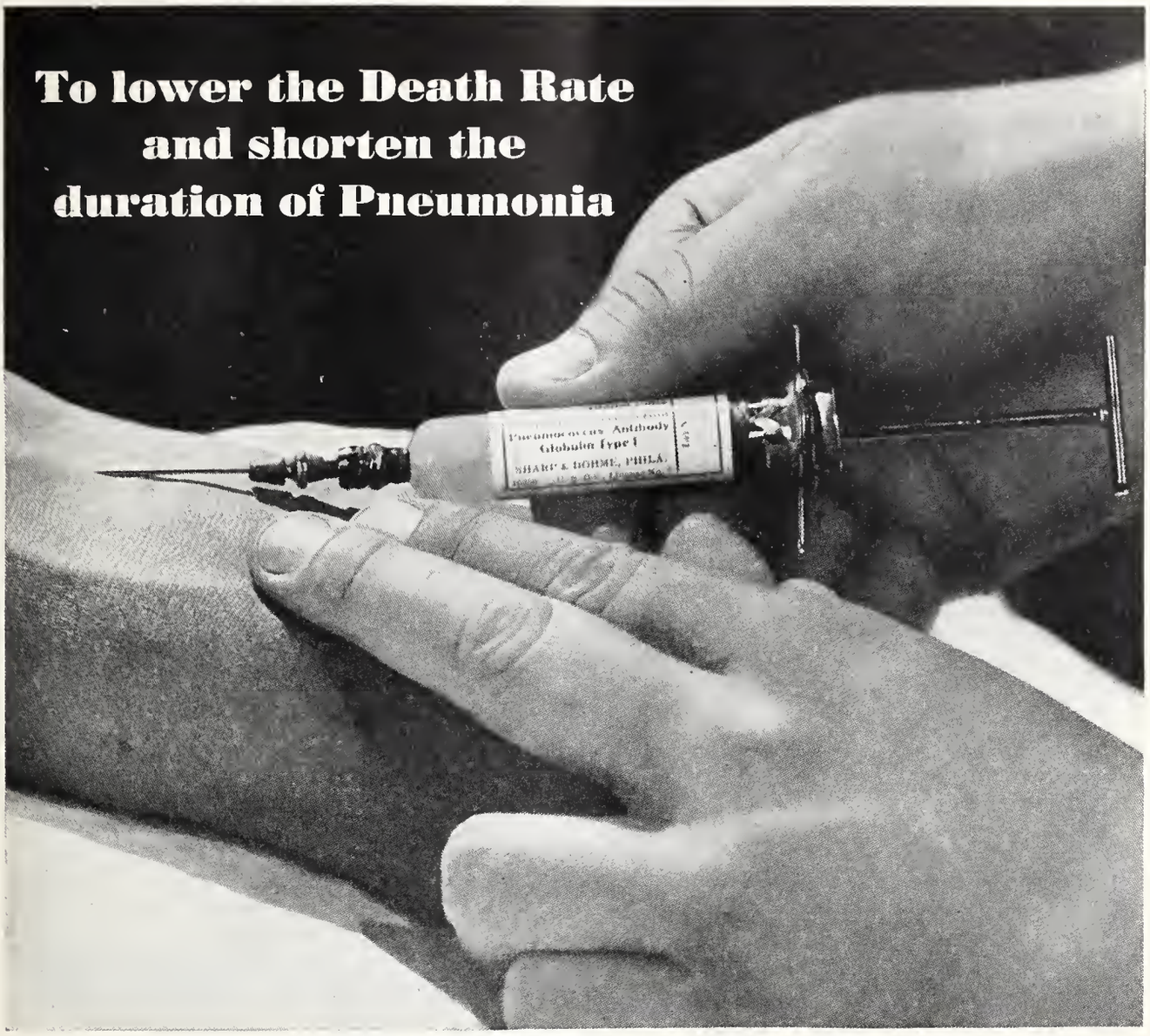
I assure you, gentlemen, this is not a subject of my own choosing, else it would have been something more profitable and entertaining. . . . As the title of this paper would imply, we do bear some relation to this "pathy" or school of practice, whether it be to our liking or not. . . . In 1901 the Legislature of California made it legal for the osteopaths to practice their profession, but in no sense to practice medicine, prescribe, give medicine, or practice surgery. . . . In 1907 came the fight between the regulars and osteopaths to restrict the latter in the further issuance of licenses under the law of 1901, and force them to submit to the same examination under the State Board, in which case they (the osteopaths) were to have representation on said board. . . . Just what is the creed, articles of faith, or principles of practice, of this school, I have been unable to find out. As near as I can learn, everything is centered in the spinal cord. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 72)

"Dr. Brandon A. Bowlin, on trial all day yesterday on charges of infraction of the State Narcotic Law, was found guilty last evening on two counts of such charges. His attorney gave notice that he will ask

(Continued on Page 18)



PNEUMOCOCCUS Antibody Globulin Type 1 Mulford, prepared according to the method of Felton, offers the physician an effective method of treating pneumonia.

The early administration of this serum is strongly advised, as clinical reports indicate that early diagnosis and adequate treatment shorten the duration of the disease and materially lessen the death rate. Definite improvement usually appears within thirty hours after administration.

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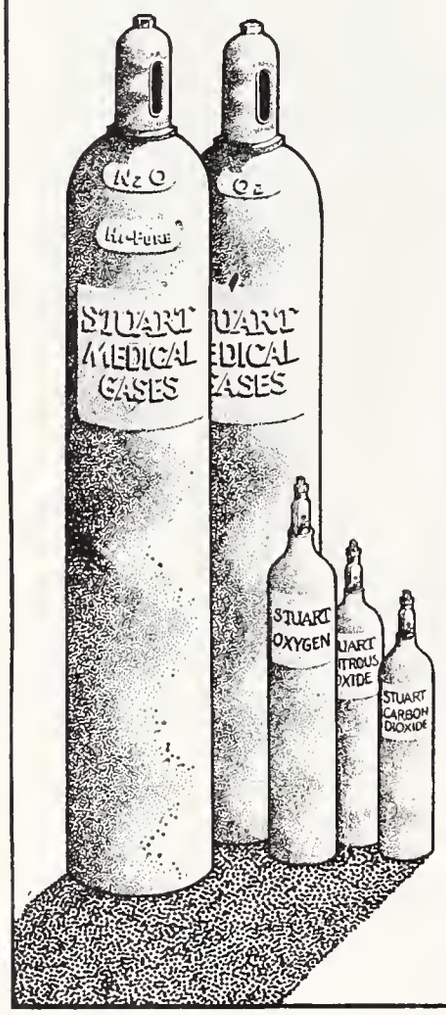
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BOARD OF MEDICAL EXAMINERS

(Continued from Page 16)

for a new trial of the case. . . ." (Pasadena *Post*, November 9, 1934.)

"Harry Kramer, Alameda County health insurance racketeer, who entered San Quentin on March 9, had his sentence fixed at two years by the State Board of Prison Terms and Paroles yesterday. The last three months will be served on parole. . . ." (San Francisco *Chronicle*, November 18, 1934.)

"A police search for J. J. Hansen, chiropractor, was begun yesterday after a coroner's jury returned a verdict that the death of Mrs. Verela Wray Newberg, twenty-one, was due to an illegal operation. Hansen, according to the police, disappeared on November 9, the day Mrs. Newberg died. . . ." (Los Angeles *Illustrated Daily News*, November 14, 1934.)

"Dr. Thomas D. Wyatt, local physician, was found not guilty of disturbing the peace in Justice Court Wednesday by Justice W. C. McCabe of Cottonwood. The charge was the result of a complaint filed by James C. McLaughlin, Wyatt's partner in the Rendezvous Dance Hall enterprise. . . ." (Redding *Courier Free-Press*, November 8, 1934.)

"Two men, one claiming to be a physician and the other a hospital orderly, caught, say police, looting a clothing store at Pine and Market streets, were booked at the city prison today on burglary and violation of the gun-law charges. One of them, Jean Val Juan, fifty-five, alias Frank Roberts, alias Frank St. Clair, has a prison record, but insisted he was a doctor and gave his address as the San Francisco Hospital. He is not known there, according to police. Neither was the other man, Rudolph Chermansck, 587 Waller Street. Val Juan in 1917 was sentenced to two years at McNeil Island penitentiary for bigamy. In 1920 he was sentenced to six months for assault on his wife, Minnie. . . ." (San Francisco *Call-Bulletin*, November 12, 1934.)

"Hopelessly deadlocked, the jury which heard the trial of Dr. Edward H. Anthony, charged with unlawfully issuing narcotic prescriptions to addicts, was discharged last night by Federal Judge William R. James. The jurors had deliberated since yesterday morning. It was announced the jury had stood eleven to one. . . ." (Los Angeles *Examiner*, November 24, 1934.)

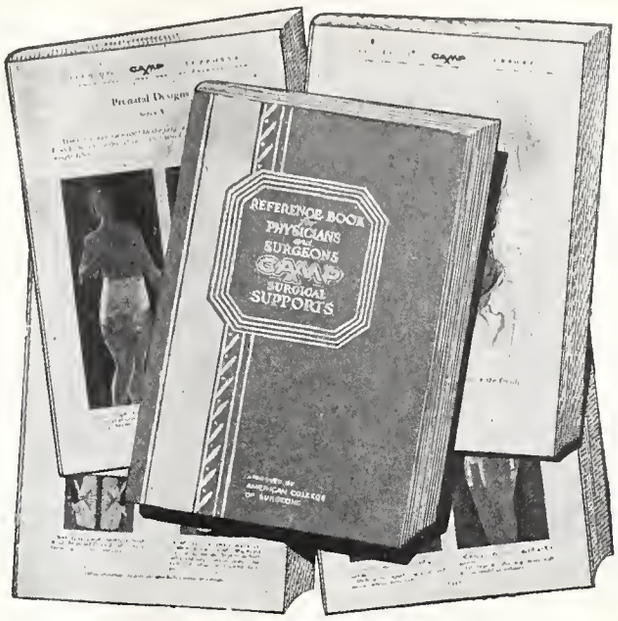
"Inferences at the preliminary hearing yesterday of L. P. Lorraine, male nurse, charged with performing an abortion, that he was framed for political reasons, were denied today by Neil McAllister, District Attorney. Lorraine is charged with having performed

(Continued on Page 21)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 18)

an abortion on Mrs. Dorothea Smalley, twenty-year-old taxi dancer. . . . Mrs. Smalley testified she was given Lorraine's address by William Kane, an acquaintance. . . . She made an appointment by telephone and then went to his home at 2764 Riverside Boulevard, accompanied by Miss Robinson. . . ." (Sacramento *Bee,* November 28, 1934.)

"Retrial of Dr. G. H. Parchen, local chiropractor, accused of murder in connection with the death of Beverly Winn, 21-year-old telephone company employee, following an alleged illegal operation, will start December 5, according to Prosecutor Oran Muir. The jury which tried Parchen a few weeks ago on the charge, failed to agree after deliberating more than twenty-four hours. . . ." (San Diego *Tribune,* November 19, 1934.)

"Yosemite Narbona, also known as Paul Ann Acker, who formerly operated the Navajo Industries Company, Inc., of Long Beach, yesterday was fined $400 by Federal Judge Paul J. McCormick after a jury had convicted him on charges of sending misbranded herb remedies through the mails. Narbona was ordered committed to jail until the fine is paid." (Los Angeles *Illustrated Daily News,* November 22, 1934.)

According to a press dispatch dated New York, December 6, 1934, printed in the Sacramento *Bee* of the same date, the Spiritual Psychic Science Church, Inc., of Los Angeles, is apparently conducting a mail-order business in certificates of ordination to the minis-

(Continued on Next Page)

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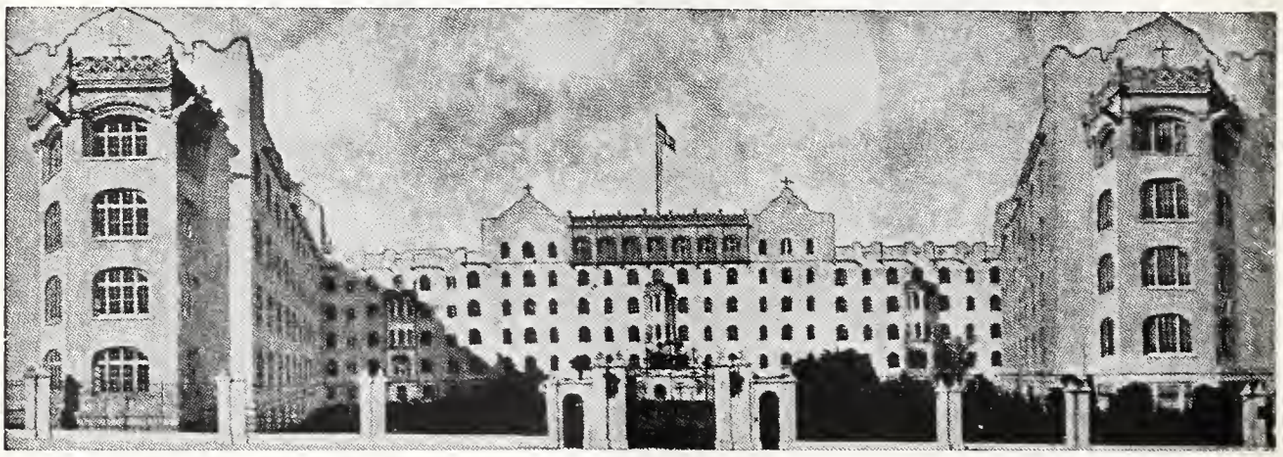
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(Continued from Preceding Page)

try. A reporter for the New York Evening *Journal*, having assertedly won $25 at a dice game, said that he spent it to become a mail-order minister by assertedly sending the amount, accompanied by the name of Joseph Dunninger, and by return mail he said he received the certificate neatly engraved, stating that he had been ordained a minister of the gospel of the Spiritual Science Church, Inc., of California, and empowered to officiate at marriages, christenings, funerals, and other services. The records of the Board of Medical Examiners show several alleged religious and spiritualistic corporations apparently formed with the idea that their members may escape prosecution for violation of Section 17 of the Medical Practice Act. The news item stated that fake spiritualistic churches in the United States "take millions of dollars from gullible men and women."

"Pleading guilty before Judge Rizor on a charge of violating Section 17 of the California Medical Practice Act, involving practicing without a license, Ted Hummel was given a sixty-day suspended sentence, the suspension to continue for two years and given on condition that the defendant refrain from practicing during that time." (Santa Barbara *News*, December 3, 1934.)

Reports relate that Nathan Harmon, who has a secret remedy which he believes will cure cancer, on December 7 pleaded guilty in the Justice Court of Anaheim to a charge of violation of the Medical Practice Act and was sentenced to serve ninety days in the county jail, suspended for one year on condition that he discontinue violation of the Medical Practice Act.

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Reports relate that on November 16 Herbert E. Young was found guilty in the Justice Court of Escondido of violation of the Medical Practice Act and sentenced to pay a fine of $100, sentence being suspended on condition that Young cease holding himself out as a doctor.

Weight-Food Relationship.*—"Food is the medicine for health," wrote Oliver Wendell Holmes. The question is to get a food that is really healthful and at the same time economical. After all, the two are the same thing. Most foods of civilized man today are neither healthful nor economical. As we look into this situation one is impressed with the fact that nature supplies a few simple but essential articles of diet, with modifications, of course, for infancy, debility, and old age. These are milk, eggs, vegetables (including roots and barks), fruits (including nuts and seeds), grains and grasses, meat (including flesh, fish, and fowl), water, and appetizers (salt, spicy flavors, and perhaps stimulants in the nature of the coffee bean, tea leaves, and cocoa). A subsistence upon this keyboard would truly constitute the "medicine for health."

An economic arrangement for diet has been promulgated by nutrition experts as follows, the sum of the figures representing a dollar spent for food:

Milk and its products and substitutes, such as butter, cream, cheese, ice cream, oleomargarine, and perhaps lard—40 cents.

Fruit and vegetables, a part of which should be fresh, the rest canned or otherwise preserved—25 cents.

Bread and cereals, some of which are to be made from whole grains, crushed or lacerated—15 cents.

Meat, preferably rare, and including animal organs, and eggs, raw or lightly cooked—15 cents.

* By E. R. Hayhurst, M. D., Chief, Division of Hygiene, Ohio State Department of Health.

(Continued on Next Page)

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(Continued from Preceding Page)

Sweets, coffee and other stimulants, salt, pepper, and flavors (each to be used, not as food, but as bait to guide the appetite to food)—5 cents.

It is on such a diet that health is known to subsist. Preferably as little elaboration in these articles should take place in preparing them as is possible. Slightly unripe fruits and vegetables are, after all, the chief reasons for cooking. The appetite alone can be used as a guide for this normal diet since none of the food items in itself creates an abnormal appetite, leading to overeating; and also, none depresses the appetite and thereby leads to undereating. The dangerous appetite is the one which is due to the elaboration of foods, and particularly that appetite which increases with eating, which means that the foods have been made up too tasty.

One's weight for his height and age is chiefly determined by four or five things:

1. His parentage, or heredity.
2. Infections lurking in the body.
3. Glandular disturbances which may be congenital but often are due to deficiencies in diet, such as the absence of iodin in food as the underlying cause of goiter.
4. Diseases of metabolism, *i. e.,* disturbances in the body chemistry which again seem to be more closely associated with the diet than any other factor.
5. Undereating and overeating.

Hence, one dieting himself in an attempt to change his weight must consider seriously whether he does not take after father or mother or some grandparent, through which his condition of underweight or overweight is hereditary. It is foolish to try to change the

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course of nature which has clearly predetermined one's weight. In fact it may be dangerous to do so.

Infections usually decrease one's weight, but they may actually increase it as in the case of heart disease, tonsillitis, and some other afflictions. Infections can be sought out and probably eliminated.

Weight disturbances due to the glands of internal secretion should be referred to specialists, and the diet by no means tampered with until so instructed.

Likewise, metabolic diseases, or those due to disturbances in body chemistry, are for specialists to treat, and some of the treatment may be dietetic, the nature of which can rarely be determined by the sufferer himself; so that he may only be adding "fuel to the fire" in "dieting" himself.

In short, the only form of underweight or overweight in which one can with safety resort to more eating or less eating is the form in which there has been too little eating or too much eating. Here again this condition should not exist (provided proper foods are available), because a healthy individual has only to resort to a natural type of diet to correct faulty appetites. A logical deduction, therefore, is that so far as weight is concerned the same diet may be eaten for underweight as for overweight!

Before one starts dieting or pursuing any of the fads of the time in regard to diet he should first try out the food scheme above suggested, and if he does not gain or lose weight in reasonable time he should seriously consider the other possible causes and remedies mentioned above. Truly, many people are adding "fuel to the fire" today by tampering with their diets. The notional person, that is, the one who avoids certain articles of diet, as well as the faddist who pursues one plan of diet, is truly jeopardizing his or her health and should consider what the effects may be after months or years. Primarily the human race is omnivorous and man's digestive and assimilative apparatus are of the kind that demand a wide inclusion of foodstuffs; and

(Continued on Next Page)

The Operation Was a Success But the FEE Died

Excerpts from Diary of Mrs. X

(May) Home from hospital, feeling fine but weak. Have a good nurse. Dr. Y. is wonderful—made his fee so reasonable, too. Took all our cash to pay hospital.

•

(June) Hoped to pay some on Dr. Y.'s bill, but nurse expensive and had to have housekeeper for month. Never felt better in my life.

•

(July) John gets two weeks' vacation, so we're going to Yosemite. Will pay Dr. Y. next month.

•

(Sept.) Just got statement from Dr. Y. Don't see how we can ever pay that big bill.

•

(Jan.) Imagine Dr. Y. writing me that letter about his bill,—and he knows how things are at Christmas. He can just wait.

•

(April) I'm not going to worry any more about Dr. Y.'s bill. He charged way too much, anyhow. Wish I could make that for a half hour's work.

•

(Aug.) John saw Dr. Y. today and told him just what we thought about his exhorbitant charge.

•

(Oct.) Dr. Y. has given our account to The Doctors Business Bureau. I know those people,—they never give up, so I guess we'll have to pay it.

•

(MORAL: Don't wait until your patients reach this stage. Let us collect before gratitude wanes, and retain your patient's good will.)

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(Continued from Preceding Page)

yet, like the lower animal, experience shows he does best when the food is served "as is," without previous selection, trimming or cooking except to render it safe from germs and parasites, or more digestible when poorly selected. A good many weight cures, anemia cures, even skin, rheumatism and diabetic cures, are being made by returning to the same thing—a sensible, natural form of diet.—*Ohio Health News.*

When Will Rabies Be Controlled?—The columns of this publication have been used repeatedly for the purpose of drawing attention to the seriousness of the rabies situation in California. This disease has been particularly prevalent among dogs in the southern part of the state. In San Diego the Department of Public Health has started an active campaign against rabies in animals. An editorial which appeared in the November, 1933, Monthly Bulletin of that department reads as follows:

"Since January 1, 1933, San Diego City has received reports on fifteen rabid dogs and three cats. All were confirmed by the laboratory as rabies. Fifteen of these eighteen cases have been reported since September 1.

"A number of persons received bites from rabid animals. Three dogs accounted for as many as twelve persons. Fortunately, all persons bitten were traced and received anti-rabic treatment.

"Our success in discovering all persons bitten by rabid animals cannot go on forever. Sooner or later will come a case that we knew nothing about, and a human case of rabies will develop. We most devotedly hope that such an event will not occur; and it will not occur if proper legislation is passed.

"Such legislation should by all means be state-wide, and should be of sufficient effectiveness to successfully prevent the development and spread of this fatal disease.

(Continued on Page 28)

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You appreciate, we are sure, that physicians, like other citizens, must pay their bills promptly. They can only do so, however, when their own clients in turn pay them promptly for such professional services as may have been rendered.

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—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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(Continued from Page 26)

"A glance at the state records for the present year confirms the necessity of a state law. The *Weekly Bulletin of the State Department of Public Health* of November 18, 1933, states that seventeen counties have reported a total of 565 cases of animal rabies for the period from January 1 to November 18.

"It is obvious that unless something is done immediately, there is a strong possibility that rabies will spread to those counties so far unaffected.

"The State Legislature will not be in session for another year, hence in the meantime cities and counties should protect their citizens against incursions of rabies."

Santa Barbara Has New Milk Ordinance.—The city of Santa Barbara has adopted a new ordinance relating to the control of its milk supply. The most striking feature of the new ordinance lies in the requirement for physical examination of milk handlers under certain conditions. The section relating to the subject reads as follows:

"Every person connected with a dairy or milk plant whose work brings him in contact with the production, handling, storing or transportation of market milk, containers or equipment, shall have within twelve (12) months or less, as required by the Health Officer, passed a medical examination made by the Health Officer or a licensed physician approved by the Board of Health of the city of Santa Barbara and shall submit such specimens of bodily discharge as the Health Officer may require. The above requirements shall not apply to any person engaged in production of milk for pasteurization, unless specifically required by the Health Officer. Every new employee 'shall,' except in cases of most extreme emergency, obtain a medical examination before assuming his duties. A health certificate signed by the examining physician shall be the only valid evidence of the foregoing examination."



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2. With arms straight, while counting one, two, swing forward, bearing weight on body firmly but not violently.

3. Swing backward while counting one, straightening up and thus relieving pressure—this allows air to be drawn into the lungs. Rest in this position for two counts.

4. Repeat these movements rhythmically, forward and backward, without interruption, about twelve to fifteen a minute, until natural breathing is restored.

Meanwhile, if assistance is at hand, a physician should be sent for, patient's tight clothing should be loosened at neck, chest or waist, and patient should be kept warm.

Patient should not be moved from this spot until he is breathing normally and then should be carried in lying position to a place where he can be kept warm and receive expert medical attention.

Return of Liquor Brought New Problems.—W. G. Campbell of the U. S. Department of Agriculture states: "Importations and interstate shipments immediately assumed tremendous proportions, and many violations of the act accompanied the revival of the industry. It was recognized that the Food and Drug Administration could not possibly supervise this entire traffic without neglecting other lines of food and drug commodities. Principal attention was therefore restricted to products sold as medicinal whisky, but not of United States Pharmacopeial purity; to imitations sold as genuine whisky; to products clearly short in volume; and to products mislabeled as to alcoholic content." . . . In addition to the actions on medicinal whisky, forty-nine seizures were made of products incorrectly labeled as whisky or Scotch whisky. As examples are cited articles composed of pomace and raisin brandy, and colored molasses spirits branded as whisky, and alleged Scotch whisky consisting of a small percentage of Scotch whisky diluted with neutral spirits and colored with caramel. Additional grounds for seizure of products sold as whisky were short volume and false and fraudulent therapeutic claims. Mr. Campbell adds: "It is self-evident that the present resources of the Food and Drug Administration are wholly insufficient to patrol the entire interstate and import liquor traffic and at the same time meet the other obligations in the way of protecting the purity of the food and drug supply imposed by the Federal statute."

(Continued on Next Page)

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(Continued from Preceding Page)

The report shows that 421 seizures of medicinal preparations bearing false and fraudulent therapeutic claims were made, and 232 consignments were made the basis of criminal prosecutions. "Preparations in this category," says Mr. Campbell, "against which action is now being directed, are quite generally of rather limited interstate sale. This does not mean, however, that grossly misrepresented proprietary remedies are no longer to be found on the market. In the absence of a Federal statute applying the same standards of honesty and fair dealing to advertising that now apply to label declarations, manufacturers and distributors of proprietary remedies have an easy method of evading the penalties of the statute by selling their products under truthful labels and continuing their extravagant claims through the medium of advertising."

The report describes surveillances of anesthetic ether, showing that only seven cans out of 1,308 individual containers examined were substandard. More than 2,000 samples of drugs other than patent medicines and medicinal whiskies were analyzed, of which 130 samples justified prosecution. Inspection of a wide range of other medicinal products is reported.—Press Bulletin, United States Department of Agriculture.

New Food and Drug Act Legislation.—In the report by W. G. Campbell on the Foods and Drugs Act, the various bills before the last Congress, designed to provide more comprehensive food, drug and cosmetic, control, are described. The bill known as Senate Bill 1944 was sponsored by the Department of Agriculture. After two hearings and material modifications, it was pending before Congress at the time of adjournment as Senate Bill 2800. Says Mr. Campbell: "The measure, in addition to preserving all of the many worthy features of the present statute, is designed to bring within the scope of the law cosmetics, mechanical devices intended for curative purposes or for affecting the structure of the body, and advertising of foods, drugs, and cosmetics. It prescribes more effective control in the case of dangerous drug products and food containing poisons or prepared under conditions constituting a health menace. More definitely informative labeling is provided for, and penalties of a more corrective character are established."

In conclusion Mr. Campbell states: "The fight for effective food and drug legislation is not ended. The months of effort already expended have not been wasted. Constructive suggestions have been developed in the course of the hearings, which will undoubtedly improve the chances for the enactment of legislation at the next session of the Congress. Most important, however, is the aroused public interest in the purity of the food and drug supply, a concern which has long been dormant. This interest, once aroused, will unmistakably grow into a united demand for effective legislation which cannot be gainsaid."—Press Bulletin, United States Department of Agriculture.

Training for Practice.—Training for medical practice should not cease with graduation. It should continue along definite lines: (*a*) the scientific principles of medicine and surgery; (*b*) the personal relation of physician to his patients, his colleagues, and to the community.

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VOL. 42 JANUARY, 1935 No. 1

MEDICO-LEGAL TESTIMONY*

By WILLIAM L. WEBER, M.D.
Los Angeles

DISCUSSION *by Joe G. Sweet, Esq., San Francisco; Philip Stephens, M.D., Los Angeles.*

FOR many years, in my capacity as chief surgeon of a large electric railway company, I have had the opportunity to hear much medico-legal testimony, and also to read many of the court transcripts of such testimony. The bulk of this testimony is, in my opinion, the honest and sincere conviction of the medical expert. On the other hand, a not inconsiderable part of medico-legal testimony is at such variance with the actual facts that one is forced to the conclusion that the witness must either be ignorant of the medical facts as obtain in the case in question, or his standards of veracity are at a low ebb indeed. I am not critical of the medical witness who is incompetent, or the one who perhaps, in his desire to give his patient the benefit of any doubt, becomes a partisan to the cause. The medical witness that I do criticize is the one who brazenly and defiantly gives downright dishonest testimony.

MEDICAL WITNESS HERE DISCUSSED

It is with the latter type of medical expert witness that I am concerned, for it is he who has created an impression not only unfavorable, but also unfair, to the medical profession as a whole.

Judge Charles Fricke in an address delivered before the Los Angeles County Medical Society in 1930 had this to say, in part, about medico-legal testimony:

"Much as we may deplore it, the fact remains that the general public has a lack of confidence in medical testimony, and that this sentiment exists in the minds of many jurors and, to an extent at least, in the minds of the judges.

"The fact that this impression is largely unwarranted does not alter the unfortunate situation. But since it does exist, it must be met; as far as it is unwarranted, it must be overcome; and in so far as it is justified, an effort should be made to overcome the cause. Until this is done, every medical expert called as a witness must not only give his testimony, but must also overcome any prejudice which may exist in the minds of those members of the general public who have to pass upon his testimony."

Thus the medical profession stands charged by an able jurist; it, therefore, behooves the profession not to remain supine and complacent in the face of such charges, but, on the contrary, to be up and doing something to remedy the evil.

DEFINITION OF MEDICO-LEGAL TESTIMONY

Medico-legal testimony may be defined as the giving of evidence in court, under oath, of such facts as are found after a searching and exhaustive investigation of the case in question. An expert medical witness is an individual selected by the court or parties in a cause, who, possessing special knowledge and experience (as distinguished from common or judicial knowledge) in medicine and surgery, is permitted to give his opinion, based upon an assumed state of facts, with the thought that his conclusion or judgment is to be of value in settling the point at issue.

THE JURY'S PROBLEMS

The medical question for the jury to decide in personal injury suits is extent of injury and the probability of its permanency.

The extent of injury is a question of fact, and is usually testified to by the attending physician. Special issues and other reasons demand the use of medical expert witnesses in many, if not in most personal injury suits. Their opinion, based upon the facts in evidence, is a most important part of the testimony. Being an opinion, it can only have weight when the jury is convinced that it is honest conviction based on careful observation and experience, and given without bias.

Probably no expert in a personal injury suit is credited by the jury as being absolutely impartial. It would be well for experts to bear in mind that from the moment they take the stand they are assumed to be more or less prejudiced; that if by their testimony, or their manner of giving it, they strengthen such an assumption, they injure more than they help the side for which they appear.

In testifying as to the permanency of the conditions found in the plaintiff, the law does not

* From the Medical Department of the Pacific Electric and Los Angeles Railway Companies.

Read before the Industrial Medicine and Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

require the witness to state beyond a degree of reasonable certainty, the court holding that "medicine is far from being an exact science." The chances of recovery in a given case are more or less affected by unknown causes and unexpected contingencies, and the wisest physician can do no more than form an opinion based upon a probability.

POINTS A MEDICAL EXPERT SHOULD OBSERVE

In giving medical expert testimony technical terms should be avoided, and when used their meaning should be explained or illustrated. The witness should not engage in a contest of wits with the opposing counsel, and under no circumstances should he lose his temper. His answer should follow the question promptly, but he should not permit himself to be led into hurried answers in his cross-examination. Many questions are put which do not permit a direct "yes" or "no" answer. Under such circumstances the witness should state that he can only answer qualifiedly and is entirely justified in maintaining that position, however insistent the cross-examiner may be in having a categorical answer.

If the expert has personally examined the plaintiff, he is expected to give the details of his examination, and then his opinion. Very thorough examinations are advisable, even when the condition is obvious; for if the expert can be shown to have been hurried or superficial, his testimony can be greatly weakened on cross-examination.

Often when the expert has examined the plaintiff, and always when he has not, his testimony is brought in relation to the case by means of a hypothetical question. The hypothetical question is founded on the facts in evidence, which have been testified to by the various witnesses. The expert is required to accept as true the assumptions made in the question, notwithstanding the fact that he is not responsible for the truth. Thus, it may happen on cross-examination that he is obliged to express an opinion based on facts he believes to be untrue. This loophole, also, makes it easily possible for unscrupulous experts to give favorable testimony based on assumptions that he knows to be untrue.

The hypothetical question requires answers as to whether the accidents described were adequate to cause the symptoms subsequently complained of, what those symptoms indicate, and whether or not they will be permanent.

CREDIBILITY OF EXPERT MEDICAL WITNESSES

The credibility of expert medical witnesses, and the weight of their testimony, are for the jury to decide; it may be disregarded by the jury if the latter is convinced that such testimony is not correct; but how are the jurors to know whether or not medico-legal testimony is correct when in so many instances exactly opposite views are expressed?

Here is where the credibility, honesty, and common decency of the medical expert witness are at stake. The witness must be a man basically honest and not to be swayed from his honest opinion, or one who will not give ridiculous or illogical conclusions. For an opinion to be competent and acceptable as evidence, the mental operation involved in its production must have as its basis rationality and reasonableness; remote possibilities or conjectures are never used as its basis.

The medical man, when he enters the contentious atmosphere of a court, must be aware of being inoculated thereby and made a partisan. For, while it may be natural for an employer to minimize a disability occasioned by injury, and for the injured to exaggerate its degree, it is not the office of the expert to take sides.

As Beaumont of Bath has rightly expressed it:

"Pity may almost unconsciously bias him in favor of an unfortunate workman or injured person; indignation may prejudice him against a man whom he believes to be a malingerer. Both must be ruthlessly cast on one side; he must obliterate all humanizing tendencies, and, leaving the legal rights to be safeguarded by the law, he must deal impartially with the abstract medical problem alone."

WHY MEDICO-LEGAL TESTIMONY IS SOMETIMES IN ILL-REPUTE

For many years medico-legal testimony has been the subject for much writing and discussion, and not without reason. There have been times when the malodorous effluvium emanating from the decadent carcass of a medico-legal trial has reached to the high heavens.

It is on account of this sort of testimony that I am forced to the conclusion that medico-legal testimony only too often is obtained at a price that is prohibitive, perhaps not so much from the viewpoint of the so-called medical expert witness who is usually well paid for his services, but prohibitive that in many instances it is a reflection directly upon the integrity and ability of the expert witness, and indirectly upon the profession as a whole.

It seems to be an occasional custom in the United States not to call as a witness any physician who, after examining a party to a suit at the solicitation of one of the attorneys, informs the attorney that his conclusions are not favorable to his side, but rather to call an expert whose testimony can be counted upon as favorable to that side. In other words, there are medical men who can be relied upon to give such testimony that the plaintiff's attorney knows will be favorable regardless of the known facts, or of such facts readily ascertainable after careful examination.

On the other hand, I know of any number of high-class and skilled physicians who refuse to examine a personal injury case because of the odium attached to the medico-legal conflict that is almost always certain to arise during the trial.

When a so-called medical expert is ignorant, careless, or incompetent (and many such qualify as experts and testify day after day), his defects can easily be exposed by an astute cross-examination; but where the medical expert is shrewd or has ability, and is hired to give dishonest testi-

mony, or to disagree with the other experts, then his testimony may, and often does, exercise considerable influence. Thus, honest difference of opinion does not, in a majority of cases, account for the difference in testimony.

The question of the abuse of medico-legal testimony has occupied the time and minds of men of both legal and medical professions for many years. That such testimony is an absolute necessity in many cases there can be no doubt; also, there is often room for honest difference of opinion, concerning which there can be no criticism. But when such opinion is not founded on basic facts as pertain to medicine and surgery, when exaggerated statements are made, when ridiculous deductions are given, when false reasoning and clever manipulation of scientific facts are allowed to enter as testimony, then does a medical witness reflect discredit upon himself and the profession as a whole.

IS THERE A CURE FOR THE CHAOS EXISTING IN MEDICO-LEGAL TESTIMONY?

What is the cure for the chaos in which medico-legal testimony finds itself? That there is a great need, perhaps not so much for more knowledge among our experts, but for more honesty, there can be no doubt.

At any rate, there exists a real problem; one that has baffled the best minds of both professions for many years, and one which today seems to be just as difficult of a satisfactory solution as ever. However, this apparent difficulty should not deter us from making persistent efforts to clear the way for a better understanding among the members of both professions.

The responsibility for the miscarriages of justice in our courts of law today are shared equally by the medical and legal professions. In fairness to the legal profession, I must say that they seem to be more drastic in their actions toward their delinquent members than are the members of the medical profession toward their erring brothers.

There should be some means by which a physician, testifying as an expert, could be held to account for testimony which differs from that of all known authorities. Medical societies ought to pay careful attention to expert testimony given by members of the medical profession, and to draw the attention of the courts to such testimony if it is at variance with facts in the possession of medical science.

Quoting from the Honorable Judge Bartlett of New York:

"The proper remedy for such evils in medico-legal testimony lies in adequate amendments in the code of ethics by which physicians and surgeons regulate their own conduct. You can decree in your code that a certain course of conduct of a medical expert witness shall be deemed honorable and professional, and that a certain other course of action shall be deemed dishonorable and unprofessional; by commanding medical experts to do what is right, and by subjecting them to professional censure and obloquy if they do what is wrong."

MEDICAL AND LEGAL PROFESSIONS BLAMEWORTHY

Thus it would seem that the onus is squarely put up to the medical profession by an able and distinguished lawyer. However, while I personally feel that in the main the doctors themselves are largely to blame for the stigmata of degenerated medical testimony thrust upon them, the lawyers, too, must share in the censure.

I blame the lawyers to the extent that, by assuming the rôle of his satanic majesty, they place before a low moral-fibered doctor a temptation too great for him to resist. Most lawyers know of certain doctors whom they employ regularly who are willing to spew their perjured testimony in accordance with the desires of the attorney and his client.

The lawyer is not supposed to know, nor to be able to interpret and evaluate, the extent of injury or sickness; hence, of necessity he must depend upon a physician for help. However, regardless of the incompetency of the attorney to evaluate the medical aspects of the case, I have never known of one to undervaluate the probable financial worth of a personal injury case.

I do blame the doctor without reservation who aids and abets in any case in obtaining undeserved compensation, by reason of dishonest, illogical, or distorted medical testimony. The doctor is supposed to know, and he should know the medical facts of the case; his testimony should be concerned only in the giving of such facts and nothing else.

On the other hand, I am sure that the great mass of the medical profession are men of integrity and whose opinion cannot be purchased at a price. The cure lies in the hands of the men who are called as medical witnesses. It is incumbent upon them to give such testimony that when the musty transcript records of the court trial are exposed to the scrutiny of their colleagues, they can face them unashamed, and with the knowledge that their testimony at least was sincere and honest.

A SUGGESTED REMEDY

But until the weaker members of the medical profession attain this high degree of moral courage, the profession as a whole must make efforts to clear the muddy waters that now embroil the noblest of professions.

As a remedy, I suggest that the Medico-Legal Committees of the various county medical societies submit a list of qualified experts to the various judges; the judge, with the approval of the defendant and the plaintiff, will call three of the experts to examine the plaintiff and render a joint report, giving in detail and in language easily understood by the lay jury the real facts of the case. Should the jury disregard the findings of the court doctors, then the judge should immediately set the verdict aside and grant a new trial.

Miscarriages of justice in medico-legal cases are not always due to dishonest or partisan medical testimony. Sometimes such occurrences are due to the fact that the usual lay jury is com-

posed of persons not properly qualified to pass on medical questions; or the medical testimony, though sincerely and undoubtedly honestly given, may be so erroneous as to cause a grave miscarriage of justice, and especially when given by men who qualify as experts and whose opinions, therefore, may have much weight with the jury.

REPORT OF CASES

Examples of two such cases that came before the courts in Los Angeles within the last few years prompted me to analyze each one carefully and thereby bring to light much interesting and useful information.

Both patients received but minor injuries; each one sued for large amounts, the one obtaining $30,000 which, together with the costs incidental to the trial, brought the entire amount to over $40,000 that the defendant corporation had to pay. In this case the doctors employed by the corporation testified that the man was recovered from all of his physical injuries; that he was suffering from a psychoneurosis, and that upon conclusion of the trial he would soon recover.

The plaintiff's doctors, on the other hand, testified that he was, to a large extent, permanently injured. The final decision in this case caused one of the railway investigators to wonder how there could possibly be such diametrically opposite medical testimony as advanced by the various doctors; surely some were right, but which he did not know; and in order to clarify the situation he was encouraged by the railway company to make an investigation of the plaintiff after the conclusion of the trial.

He found that the man had disappeared from his usual haunts, and was nowhere to be found. However, about two months later he found him in Mariposa County, where he had purchased a gold mine and was vigorously engaged in all the arduous pursuits that the assembling and erecting of mining machinery entail.

Motion pictures were taken during a period of two days, unbeknown to the then recovered plaintiff, and which proved beyond question that the man had recovered. There was, of course, no financial redress, but there surely was obtained a moral victory in the satisfaction of proving that the man was not seriously or permanently injured, and that the doctors who testified on behalf of the railway were correct in their interpretation of the case.

The other case, despite the testimony of his medical experts to the effect that he was suffering from a severe and disabling injury, was frustrated in his unreasonable demands for $78,000, by the showing of motion picture films which definitely proved this plaintiff to be an unmitigated liar and his doctors in profound error. These films were taken at various times during the month immediately preceding his trial. They were put in evidence after his own doctors had testified as above noted; and although they were mute, they were most eloquent testimony in proving the rascality of the allegedly injured man.

418 Pacific Mutual Building.

DISCUSSION

Attorney Joe G. Sweet (405 Montgomery Street, San Francisco).—As a lawyer, I have spent a good portion of many years as a trial defense counsel in ordinary negligence actions and also in malpractice cases. In this capacity, I have been an interested spectator, with an advantageous position on the sidelines.

I agree with Doctor Weber that every effort should be made to eliminate the dishonest and the ignorant from the ranks of the medical profession. Much may be done by the profession itself, but when all that is humanly possible has been done, a considerable number of the unfit will remain. This will be true of all professions so long as humanity remains fallible.

Large verdicts are not awarded healthy persons solely because of the incompetency or dishonesty of the physicians testifying in their behalf. In all too many cases the award comes as the result of an honest mistake of a well-trained medical man.

It is my opinion that much of the trouble arises from too much credulity on the part of the physician in taking the history of the person under examination. The examining physician does not sufficiently take into consideration the difference in value of the histories of the paying patient who voluntarily comes in for treatment and the claimant in a tort action who is attempting to recover high compensation for his injury.

The physician is justified in believing that the regular patient has any pain indicated, or what is just as important, that he thinks he has. It is fair to assume that the patient is not going to pay for the privilege of attempting to deceive the doctor.

On the other hand, the patient who is referred to a doctor representing a defendant occupies an entirely different position. Probably before arrival he has been coached by another physician, or by an attorney skilled in the trial of negligence cases. More frequently than is thought, he has made some independent study concerning the affliction from which he claims to be suffering and has trained himself to deceive. His statement of suffering is entitled to little weight unless independent physical findings confirm.

The problem that now confronts the profession is to develop new and efficient means for determining the truth of what is told. An actual case that I have in mind will perhaps illustrate the correctness of what I here say.

In the case I have in mind, plaintiff was injured on September 23, 1930. X-ray films taken immediately following the injury showed a "right anterior rotary displacement of the first cervical vertebrae on the second." On September 25, 1930, the dislocation was reduced and the x-rays showed "that the dislocated first cervical had been replaced to its normal position."

The case came to trial in April, 1933. The plaintiff presented a pitiful appearance in court. His step was uncertain and his head was tilted forward on a rigid neck. He contended that he was unable to raise his arms above the level of the shoulders. The head movements were greatly limited. He also complained of difficulty with sight and hearing.

Over a period of years prior to trial, he was examined by physicians representing his Workmen's Compensation carrier. His doctors were not of his choosing and it was to their interest to find that he was malingering, if such were the case. Both examiners were men of ability and of unquestioned integrity.

As the result of examinations made on November 20, 1931 and September 12, 1932, and also immediately before trial, the examiners reported the patient to be totally disabled.

Prior to trial the defendant placed a motion picture operator on the trail of the plaintiff. Pictures were produced at the trial and showed him romping with his sweetheart, raising his arms above his head, and going through all motions that could be made by any normal healthy man. Another set of pictures showed

him rowing a boat upon Stowe Lake. Following the presentation of these pictures in court, the plaintiff was convicted of perjury and sentenced to jail.

This is just one of many cases in which a plaintiff has completely deceived the examining physicians. After nearly twenty years of experience in the trial of negligence cases, I am coming more and more to the opinion that an astonishing number of permanent injuries, if studied with a motion-picture camera before trial, or if followed and studied after trial, would reveal just what this motion-picture operator fortunately found before it was too late.

PHILIP STEPHENS, M.D. (1136 West Sixth Street, Los Angeles).—I think the best lesson to be learned by this most excellent paper of Doctor Weber's is a simple fundamental fact, namely, that when on the witness stand we should state facts. In other words, tell the simple unvarnished truth when we can, and qualify our statements if it is necessary to do so, and not allow our opinions to be swayed by either side in the case; to never, by any word or statement, give any judge or jury the faintest reason to suspect that we are what is known as a paid advocate, a thought which is always in the mind of, at least, the jurors, largely due to the fact that we are summoned by either one side or the other in the case; that it is neither right nor honest to favor, or show a tendency to favor, plaintiff or defendant, whether a private individual or corporation, rich or poor, by word or deed. In short, justice should be blind, but the law looks to us to properly evaluate the degree of disability and we should attempt to do it honestly and with favor to none.

A great deal of his paper could have been gotten from any medical jurisprudence, but the advice relative to its application and practical use is, without question, invaluable, and we hope that much of the information contained therein will be presented again and again so that all doctors may be sufficiently informed, and act so that at least some of the odium which we have borne in the past, in the matter of medical testimony, may be forever removed. We are glad to note the sincere effort on the part of the legal fraternity and Bar Association to coöperate with us, and to be working with us toward that end.

THE MEDICAL AND SURGICAL ORGANIZATION AT BOULDER DAM*

By RICHARD O. SCHOFIELD, M. D.
Boulder City, Nevada

DISCUSSION *by R. A. Bowdle, M.D., East Ely, Nevada; R. F. Palmer, M.D., Phoenix, Arizona; J. C. Geiger, M.D. San Francisco.*

THE physical organization of construction programs heretofore has seldom afforded an opportunity for the coördination and the complete centralization of the various phases of work such as come under the head of Industrial Medicine and Surgery, as has been the case at Boulder Dam.

An attempt is here being made to enumerate and evaluate the subdivisions of industrial work, particularly in regard to public health problems, water supply, sewage disposal, school problems, industrial hygiene and safety, first aid, surgical repair, compensation insurance, hospital management, and medical legal aspects, as they have presented themselves on the project which is being constructed by the Six Companies Inc.

*Presented at the thirty-first annual meeting of the Nevada State Medical Association at Reno, Nevada, September 22, 1934.

CIVIC SET-UP AT BOULDER CITY

Boulder City was established and built by the Department of Interior through the Bureau of Reclamation in 1931 on part of what has been designated as the Boulder Canyon Project Reservation, which is located in the southern-most portion of Nevada. It is situated twenty-four miles from Las Vegas, Nevada, at an elevation of 2,500 feet, and is eight miles from the site of the Boulder Dam which is being constructed in the Black Canyon of the Colorado River. It is connected with Las Vegas by a paved highway and a branch of the Union Pacific Railroad. Electricity is brought to the city from Riverside, California, 225 miles distant, by a direct high-voltage transmission line. The city is governed by a city manager, who is employed by the Secretary of the Interior. Policing of the city and the entire reservation is in the hands of Federal officers. Originally the plans called for a city of about 3,500 people; the present population is more than six thousand. Upon completion of the construction work, only a small portion of the city will remain with an estimated population then of from five to eight hundred people. Permanent structures include a modern, air-cooled hotel and a theater, some commercial houses, school, hospital, Bureau of Reclamation office and dormitory, municipal buildings, and a few residences.

The Bureau of Reclamation is the designer of the Dam, with Walker R. Young in charge as construction engineer. The Six Companies Inc. are the builders of the Dam, with Frank T. Crowe in charge as superintendent of construction. The contract price for the completion of this portion of the Boulder Dam project is $49,000,000. The Babcock and Wilcox Company hold the contract of $11,000,000 for the steel piping used in the tunnel linings.

PUBLIC HEALTH ORGANIZATION

As health officer it is necessary to correlate various requirements of federal, state, and city regulations. Centralization gives a smooth, efficient organization, which at all times has received the unqualified support of all three agencies.

Garbage removal is effected through its collection in the early hours of the morning in properly equipped and, where necessary, covered vehicles, and it is disposed of by incineration and use as food for hogs in near-by communities.

Food handlers employed in the stores, restaurants, fountains, and commissary are examined as to the presence of skin disease and venereal infections. Physical cleanliness and proper sterilization of equipment used in these places of public service are demanded.

The graded school has an attendance of about seven hundred pupils, and approximately nine hundred children of the preschool age live in the city. A full-time school nurse is employed whose activities are directed toward the care of the general health of the school child in regard to supplementary feedings for the undernourished, inspection of the children for possible acute infections, eye trouble, and static deformities. Her

services are also extended into the various homes when necessary. One hundred and sixty students attend the high school in Las Vegas.

Contagious diseases are controlled through effective measures of isolation in the home and the removal of patients to isolation premises. The usual exanthemata are found, but only in the case of measles have we encountered an epidemic. There have been no cases of infantile paralysis. Perhaps a splendid example of the thorough cooperation that is shown in the city was afforded some fifteen months ago when three cases of smallpox were found in one day, and on the next day four more cases appeared. A careful check showed that all of these occurred in one and the same dormitory which was operated by Six Companies Inc. One hundred and seventy-seven occupants of this dormitory were men who worked during the various three shifts of employment of the day. This dormitory building was scrubbed with lysol and water, and this scrubbing included the floors, the walls, and the windows of every sleeping room, closet, hallway, and toilet in the building. Each mattress and pillow was carried to the outside and sunned for two hours, and then turned and sunned on the other side for two hours, and then replaced in the cleaned rooms. All washable linen and blankets were removed and a complete fresh supply of these articles was furnished to each room. A fresh supply of vaccine was obtained by air express, and all of these men were inspected and vaccinated. The above procedures were carried out in a period of fourteen hours, and the usual rest of any employee who lived in this dormitory was not disturbed. The whole program was completed within forty-eight hours from the time of the appearance of the first case of smallpox.

WATER SUPPLY OF BOULDER CITY

The water supply of Boulder City is obtained from the Colorado River at a point about three-fourths of a mile below the Dam site. The entire system, which includes the collection, pumping, filtration, and distribution, and which cost in excess of $750,000, was built by the United States Bureau of Reclamation. The plant is designed to treat two million gallons daily with what is known as the "excess lime and soda ash treatment," and was adopted upon the recommendation of their consulting engineer, Mr. Burton Lowther. The operation of the plant is under the direction of D. M. Forester, who is establishing a record in the field of practical water chemistry and bacteriology. The average daily pumping is one million gallons. The Colorado River is not only a rapid stream, but it is a very turbulent and muddy river, which carries an average of 6,000 P. P. M. of suspended solids and 1,700 P. P. M. of dissolved solids. The preponderant mineral contents show the presence of Na 118 P. P. M.; Ca 93 P. P. M.; and Mg 33 P. P. M. The water is very hard, and the hardness as $CaCO^3$ averages 367 P. P. M. The fluorin content of the raw water is less than 0.1 P. P. M., and this amount is reduced by half after routine chemical treatment. The allowable fluorin content is considered as 3 P. P. M. The question of fluorin has been brought up because during the past few months there has been considerable concern expressed over the high fluorin content of the water that is used for drinking purposes in Boulder City. The statement has been made that the teeth of our children are soft and crumbling, and that there is interference with normal dentition. From my own examinations of the children who live here, it is not true that the above defects can be shown to exist in any greater proportion in this community than elsewhere. The operation of the water plant effects the delivery of a potable water supply through presedimentation, aeration, softening, recarbonation, filtration, and chlorinization. Presedimentation for four hours in the intake tanks on the river removes 98 per cent of the suspended solids. The water is then pumped six miles against a static head of 1,900 feet through two pumping stations. At its point of delivery in Boulder City it is aerated, which removes CO_2 and also oxidizes minute organic materials which are present. From here it enters the clarifiers, where is added the lime and soda ash which give a chemical combination to produce flocculency for a sedimentation of the $CaCO^3$ hardness. The excess of these chemicals which are added leaves the water very caustic, and this causticity is later reduced by passing through CO_2 for half an hour. Sand filters now remove the fine sediment, and the water is then chlorinated upon its delivery into the distributing mains. This treatment requires the daily use of two thousand five hundred pounds of lime, one thousand nine hundred pounds of soda ash, and five and one-half pounds of chlorin. The filter plant sludge which is thereby removed consists mostly of calcium carbonate, and averages in amount twenty cubic yards daily. Daily presumptive tests are run on the tap water, and each test is carried on to forty-eight-hour completion on agar plates. The B. coli index of the raw river water is 3.18. The U. S. P. H. standard allows a 0.01, while the average analysis of delivered potable water is 0.005, indicating a wide margin of safety.

SEWAGE

The sewage plant is of the split sludge digestion type, being built and operated by the United States Bureau of Reclamation. The plant cost in excess of $50,000, and is designed to care for 0.5 M. G. D. of sewage. The incoming raw sewage is strained through trash bars which remove the coarser particles, and it is then passed into clarifiers, where solids are removed by sedimentation. Ninety-eight per cent of the contents are run off as a supernatant fluid and piped for some two miles, where it flows out over the desert and is bacteriologically free at this point. The sedimented solutions are then pumped into the digestion tank, which is fitted with a gas-tight dome. Digestants in the order of their occurrence consist of the protein group followed by the denitrifiers, the fat-splitting and the cellulose digestors, which produce the end-products of methane and H_2S, some CO_2, and sterile solids. About ninety cubic feet are digested daily with an output of

four and one-half cubic feet of sludge. The methane gas which has collected in the dome of the digestion tank is used to heat water that is circulated through coils that keep the contained temperature of the digestion tank at 90 degrees Fahrenheit, allowing digestion to proceed at an optimum rate. Surplus methane is burned in an outside incinerator, to which is added the coarser particles removed from the trash bar. Sewage plant sludge is bacteriologically sterile and is used for fertilizer on lawns at Boulder City.

MILK

The standards set by the state laws of Nevada for the production, analysis, and distribution of milk are in effect on the Reservation. Private dairies supply the residents of Boulder City. The commissary of Six Companies Inc. is supplied by milk from their own dairy, obtained from 125 tuberculin-tested cows. This dairy is located about one hundred miles from Boulder City, and is an entirely modern plant in every way. The milk is precooled and refrigerated, transported to Boulder City, and served to the men as raw milk without any pasteurization. To be able to do this, in the face of excessive summer temperatures of more than 115 degrees, obviously requires meticulous care of the milk at all times. It is interesting to note that no water- or milk-borne diseases have been encountered in Boulder City, with the exception of one case of typhoid fever, which occurred in a young girl in whom the source of infection was definitely traced to the use of home-made butter brought to this family from a ranch in the State of Idaho.

Some months ago when the amebiasis epidemic was first made known in Chicago, it seemed very probable that we might expect the occurrence of an outbreak in our locality because of the constant turnover in employees who are accepted from every portion of the country. Our precautions at this time were that no food handler was employed who gave a history of having worked in the vicinity of Chicago for a period of six months prior to the time of his application for employment here on this project. To date we have had no cases of amebiasis.

INDUSTRIAL HYGIENE AND SAFETY

The dormitory quarters which are furnished to the single men include single furnished rooms with a small porch, these rooms being cooled by refrigerated air in the summer, and heated with hot air in the cooler months. The original plans for operation of the housing problem here at Boulder City did not include such measures as delousing and detention facilities previous to permanent dormitory residence. Approximately sixteen hundred men are cared for in the dormitories with accommodations that range from one hundred to two hundred men each. Regular inspections are made of these premises, and it has been my pleasure to find that they are always clean, particularly as regards washrooms and toilets. Strong efforts are made to see that the men wear slippers or some form of foot covering at all times when in the dormitories. Several cases of athletes' foot have occurred, but at no time has it ever assumed the semblance of an epidemic. The bedbug pest is cared for by cyanid fumigation, and complaints from this source of annoyance are rarely made. Such fumigation is carried out under direct supervision and in accordance with the State regulations. The menace of flies is not met with in this desert community to any great extent, but no doubt this is in a great measure controlled by the prevention of the existence of breeding places.

SAFETY

Since the beginning of the project particular attention has been paid as to the safety of employees, primarily in regard to the prevention of accumulative powder smoke and bad air conditions that might be present in the extensive tunnel work. Positive ventilation systems were installed and qualitative determinations of air conditions were carried out by experienced safety engineers throughout the entire construction period. Dust masks and inhalators were worn by workmen in the occupations where the same were required. Protective helmets, not unlike those used in the late war, but which are constructed of a very resistant *papier mâché* material are supplied to all workmen. Actual concrete workers wear rubber boots, both for their own convenience and for the prevention of disabilities resulting from working in the concrete. Protective devices are always used where possible on all types of machinery. I believe it is quite definitely shown that the best work in safety prevention is done by the foreman, and he can be relied upon to handle the situations arising in his particular sphere of the work perhaps as well or better than a safety inspector.

EMPLOYMENT REGULATIONS

Employment on the project is possible only through the facilities of the Federal and State Employment Bureau, which is located in Las Vegas. To date there have been some 19,000 men examined, with 850 rejections. The physical infirmities for rejections in the order of the occurrence are: cardiac and vascular disease, 300; hernia, 200; defective vision and hearing, 180; and the balance, due to manual deficiencies and other causes. Geographical distribution shows that California leads and is closely followed by Nevada in supplying the greatest number of men accepted for employment, being 4,500 to each State. Utah, Washington, Idaho, Texas, Oklahoma, and Missouri follow in the order named, with the remainder being divided among all of the other States. About 1,600 ex-service men are now working, and the proportion of married to single men is five to four. The average age of employment during the summer months is 31.6 years, and in the cooler months the average is raised to 34.5 years. At this time more than 4,100 men are employed by Six Companies, Inc., 300 by the Government, 220 by Anderson Brothers' Supply Company, 250 by the Babcock and Wilcox Company, and 150 by the Boulder City Company. The maximum employment at the time the project was begun was considered to be about 2,200 men, and living accommodations available for this number,

both as to dormitories and as to houses, were based upon this figure. With the number of employees doubled, it has been necessary for the men not only to live in Boulder City, but great numbers live in Las Vegas and in small mushroom communities near by. The Six Companies Inc. have about seven hundred two-, three-, and four-room cottages available to married men, which are rented on a scale according to the type of house occupied. Single men live in the dormitories and board at the mess hall, which is capable of seating 1,200 men at one time and is operated by the Anderson Brothers' Supply Company. Sufficient diversity of foods is afforded, so that a man who may be on a restricted diet, as in the case of a nephritic or a diabetic, can obtain a necessary choice of food. They are charged $1.65 per day, which includes board, room, and five cents per day hospital fee. The lowest wage paid is $4 per day for eight hours' work, and the average wage is $5.31 per day.

CARE OF INDUSTRIALLY SICK AND INJURED

Compensation insurance is carried in the State funds of Arizona and Nevada. At the present time the experience record on the project determines the rate of premium that is paid. Constant endeavors are made to provide maximum efficiency in safety, and this, together with competent medical and surgical care, materially reduces the rate of premium on these compensation policies. Medical and surgical care for the injured man is furnished by the Six Companies Inc. through the facilities of their hospital department. Two completely equipped first-aid stations, in the hands of three competent and experienced first-aid men, are operated at the site of construction, one station being located in the Canyon and the other situated on the brink of the Canyon wall. An average of more than one hundred cases daily report for all classes of treatment at these stations. Ambulance service is in effect direct from the stations to the hospital, requiring an elapsed time of about twenty minutes to transport the injured between these points. The hospital is a permanent structure costing in excess of $90,000, is located in Boulder City, and has a capacity of sixty beds with an average occupancy of thirty-one beds. It is fully equipped with standard hospital appliances, which include stationary and portable x-ray and fluoroscopic units, diathermy, infra-red and mercury quartz lamps. There are facilities for complete blood and urine work, and a pharmacy of sufficient size to care for our needs. Five doctors comprise the staff, all of whom are graduates of Class A medical schools, and who have had postgraduate and residence work. Only registered graduates are employed on the nursing staff, which averages eight in number. A competent radiographer is in charge of the x-ray department in conjunction with the administration of the pharmacy. The hospital management is effected with the aid of an auditor, who devotes his entire time to this work, and an office secretary, who has charge of records and files. Four orderlies and a cook comprise the remainder of the staff. A fee of $1.50 per month is paid by each employee and the sum of $1 per month is paid by the Six Companies, making a total of $2.50 per employee that is received by the hospital fund. This provides a working fund for medical and surgical care rendered to the employees on the project. Our average meal cost is thirty-eight cents. The average cost per nursing day is $5.15, and the cost per day per patient in the hospital is $9.10.

Up to September 1, 1934, there have been expended twenty-five and one-half million man hours of work in the construction of the Boulder Dam, which means that it would take one man eight thousand years to carry out this work alone. Work is carried on twenty-four hours each day, seven days a week, and approximately 1,200 men are employed in each of the three eight-hour shifts. With the employment of about five thousand workmen on the project and in Boulder City, we find that the occupations include practically every form of work that is done by man. We might mention that here we find miners, muckers, carpenters, plumbers, electricians, engineers, a complete coterie of railroad employees, clerical force, commissary attendants, truck drivers, riggers, mechanics, chemists, steel workers, cement workers, and all forms of general labor. From the diversity of these occupations the nature and type of injury received covers practically every field known. Over 4,300 reportable industrial injuries have occurred. There is an average of four to fourteen accidents each day, which require the attendance of a doctor. Hospital entries are from one to seven per day. Industrial deaths to date since the project started number seventy-four; non-industrial deaths among the workmen are seventy-two in number. Patients requiring treatment in the outpatient department average two hundred per day, with a maximum of three hundred and fifteen having been cared for during a period of twenty-four hours. An average of thirty-three x-rays are taken daily. In the past eighteen months we have cared for nine hundred and nineteen fractures, and nineteen major dislocations. For the most part these fractures were reduced under two per cent novocain introduced locally into the site of fracture, and in some instances, of course, no anesthetic was necessary. For the most serious cases, we have administered ninety-two spinal and fifteen ethyl chlorid, seven ether, and two brachial anesthetics. We have had no severe current nor after-results following the spinal anesthetics. In fact, it is a rare thing to have even a mild reaction. Perhaps the outstanding fracture figures are the relatively few femur fractures seen, and the high number of os calcis (32), astragalus (25), tarsal scaphoid (20), and vertebral body fractures (32). About 15 per cent of these fractures are compounded, and in many of these instances direct reduction of fragments was possible at the time of care for the compounded injury. The pin method, as advocated by Boehler for the reduction of fractures, is always used whenever the same is possible. Only six elective open reductions have been done. We make use of the direct application of a non-padded cast for immobilization. Twenty-one herniae have been repaired surgically. Thirty-six cases of pneumonia

have been treated, with five resultant deaths. Heat prostration has continually been an existing menace on this project, but by educational, preventive measures, and by the institution of prompt therapeutic measures, both of which involve the adequate use of normal saline and water, we have been able to reduce the number of cases that do occur, and during the past three years there has not followed a death from this cause.

I believe that the very strict management and care of compounded soft tissue wounds has shown very definite results in the very small number of infections that occur, and in minimizing the amount of disabilities that ensue. When a patient presents himself for treatment, the clothing is removed from the immediate area and the surrounding skin is cleansed with benzine or with green soap and water, and dried with ether and then painted with tincture of iodin. A sterile dressing is then laid on the cleansed area and the wound is cared for by scrubbing it out with green soap and water, followed by lavage with sterile water or saline. No iodin or other caustic is used within the wound itself. The tissues are carefully debrided, and devitalized portions are cleaned out and cut away. In the deeper wounds which involve tendons, primary tendon sutures are always done. The skin and subcutaneous tissues are sharply excised and wounds are closed tightly. Compounded injuries involving the skull, particularly the sinus areas, may be drained for twenty-four hours. Lacerating wounds extending through all structures of the cheeks or lips are always closed tightly and, likewise, the wounds of the eyes and orbital area.

MEDICO-LEGAL PROBLEMS

A very important part of industrial medicine at Boulder City is concerned with medico-legal cases. Because of the very complete coverage of all kinds of labor involvement on the project, innumerable opportunities are offered for the presenting of complaints that may establish legal basis for suits against the employer. These usually take on the aspect of impaired health and disabilities incurred that cannot be connected with the compensation laws of either Nevada or Arizona. The best defense for such suits is in very complete detailed records of examination, first-aid visits, medications, treatments, hospital entries, and special reports, as indicated in blood chemistry and perhaps along neurological lines. The contained detail from these sources must then be analyzed and correlated, and presented in proper form for use by the legal staff. To date only one major suit has been tried, in which there was requested $76,000 for disabilities resulting from what was claimed to be the effects from exposure to existing tunnel conditions, the plaintiff having been employed as a truck driver during the course of construction of the larger tunnels.

SUMMARY

Complete records are being kept in all departments that will ultimately be available for use in obtaining further definite statistical information in all scopes of industrial medicine and surgery as has been herein outlined, particularly in regard to the effects of treatment and results that may be expected in terms of percentage of loss of function of a disabled man, or in the efficiency of operation of any unit of the organization.

Six Companies Hospital.

DISCUSSION

R. A. Bowdle, M. D. (Chief Surgeon, Nevada Consolidated Copper Corporation, East Ely, Nevada).—Doctor Schofield is to be complimented on his presentation of a most interesting paper. Certainly, it has covered the situation at Boulder Dam most completely.

It has been my pleasure to visit Doctor Schofield and see the excellent organization of which he is the head. The hospital is modern and very well equipped. The surgical work which is being done by himself and his staff is excellent. The employees of the Six Companies, Inc., are most fortunate in having him head their medical organization.

To those of us who have been connected with large industries over a period of years, it is a great satisfaction to see the development which has taken place in industrial medicine. It is a far cry from the days of the old "contract practice" to the present efficient and well-trained medical department of a large corporation. Certainly, in no branch of medicine does the patient receive more careful or more complete and competent care than from these well-organized medical departments.

The manner in which Doctor Schofield has handled the sanitation is excellent. The experience gained from his care of the heat-prostration cases is most valuable. The results of his observations and treatment along this line will undoubtedly be a guide to other employers in hot climates. It is most interesting to note how well the contagious work has been handled. It is only by paying attention to the sometimes seemingly trivial details that epidemics may be prevented. So far as the traumatic work is concerned, the Six Companies Inc. has been engaged in a most hazardous undertaking. I am surprised that there have not been more fatalities. I would like to pay tribute to the Nevada Industrial Commission for their excellent cooperation in the handling of compensation cases. It is indeed a pleasure to work with a commission that is as fair and just as this one. It is most interesting to note Doctor Schofield's manner of handling his traumatic work. Probably the excellence of his results is largely attributable to the care that the injured man receives and the promptness with which it is given. Three factors are important in this work: time of treatment in relation to injury; the thoroughness of the first treatment; and the careful follow-up, involving the obnoxious details necessary in the treatment of fracture cases. The work of Boehler has added greatly to the better results obtained in fracture work. Spinal anesthetics in the treatment of fractures, and dislocations of the lower extremities, have made for greater ease and more accurate reduction, thereby improving the end-results. We have used the Roger-Anderson technique and are very well pleased with the results obtained by it.

Relative to the medico-legal aspect of industrial medicine, it may be said that it presents many trying and bothersome angles. The necessity of complete and accurate records is essential if one is to be able to disprove some of the fraudulent claims.

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R. F. Palmer, M. D. (Medical Referee to the Arizona Industrial Commission, Phoenix, Arizona).—On considering the discussion of Doctor Schofield's presentation of the industrial, medical, and surgical organization at Boulder Dam, one is immediately impressed by the immensity of the work and the diversity of problems falling on the shoulders of the chief surgeon; problems perhaps as great and complex as those involved in the construction of the dam itself, and assuredly forming an important integral part in the

successful consummation of this great engineering monument.

As medical referee to the Industrial Commission of Arizona it has been my duty, as well as my pleasure and privilege, to visit the Boulder Dam project at more or less regular intervals, for the purpose of examining and rating workmen injured in the course of employment and coming under the provisions of the Arizona Workmen's Compensation Laws.

My first thoughts in visiting this model city and project in operation, so complete in every detail for the carrying on of a tremendous work with every safeguard and convenience for the health, safety and comfort of the workmen, were those of comparison; contrasting conditions here with conditions present during the construction of the Roosevelt Dam in Arizona, where more than thirty years ago, as chief surgeon on that project, I was confronted with many of the industrial, medical, and surgical problems which are found here at Boulder City, but under vastly different environment and circumstances.

Our Roosevelt "model city" was scattered irregularly over a dusty hillside on the banks of the Salt River, and our buildings (except for the office, blacksmith shop and a few dwellings at headquarters camp constructed of fresh-hewn and uncured Arizona pine) were made up of temporary canvas structures. We had no railroads to the project, or even paved roads. In fact, we had *no* roads in the *early* days of the work; and there were no automobiles or motor trucks to use on them if such roads had existed. Early transportation was effected by means of horseback and pack animals, with later the Concord stage coaches and twenty-mule jerk-line teams traversing narrow mountain grades. We did have electric power after a time, this being one of the preliminary developments on the project which added much to the comfort and convenience of camp life. Our dormitories were scattered tents in scattered camps, extending for seventy-odd miles along the Salt River and to the pine timbers in the Sierra Ancha Mountains. Our hospital was termed a field hospital and, like the other buildings, was made of canvas stretched over fresh pine boards. We had no x-ray laboratory or other scientific equipment so necessary for the demands of a first-class hospital of today. Our water supply, however, was simple and efficient—a mountain spring, dammed up and piped by gravity to the storage reservoir, where the only chemical treatment required was an occasional dose of copperas to control the excessive reproduction of algae. Nature also provided ample bathing facilities, for adjacent to the main camp were adequate hot springs with a large pool, and for those who preferred cold baths, there was always the river. Although the summer temperature was high, we had no particular difficulty with insulation or sunstroke, because the Salt River at that time carried 2 per cent by volume of sodium chlorid. Garbage was taken care of by hogs and incinerators. Cloudbursts, which were frequent in those days, washed away the empty tin cans at irregular intervals, and sanitary squads with ample supplies of lime kept the various individual and collective latrines in condition to pass inspection. The officers' quarters at Roosevelt were provided with modern toilet equipment. Sewage disposal for this small community was handled by means of a settling and fermentation tank, with an aerobic film-rock filter. This plant was one of the very early septic tanks constructed in the United States, and has continued in successful operation to this day.

In spite of these seeming drawbacks to modern sanitation, there occurred, during the building of the dam, but seven cases of typhoid, some twelve cases of malaria—imported from our neighboring State of the West—an occasional looseness of the bowels not to be considered dysentery, and a few sporadic cases of ordinary contagious diseases.

The chief surgeon on this project visited the various camps on horseback, and for a hospital staff he had one third-year medical student as an assistant, and one ex-army aide trained in the Philippines for an orderly. Emergency operations were performed "as was," and where found. It is needless to say that the open reduction of fractures was not looked upon with favor, and was avoided in all cases whenever possible.

With this background, and after a lapse of so many years, it is needless to comment further on the tremendous impression made upon me on the occasion of my first visit to Boulder Dam. You will pardon, I am sure, this slight digression from the subject-matter under discussion, for, as stated by Doctor Schofield in his introductory paragraph, "the physical organization of construction programs heretofore has seldom offered an opportunity for the coördination and centralization of the various kinds of work that come under the head of industrial medicine and surgery, as has been done at Boulder Dam." The fact that this opportunity has been so taken advantage of and so thoroughly worked out, is one to be commented upon, but the efficiency with which all problems of public health and industrial hygiene and safety have been carried out and so well detailed in the presentation by Doctor Schofield, leaves but little, if anything, to be added.

My particular interest in the problems presented lies in the medical care and restoration to function of the workmen who, in spite of the careful preparations and innumerable safety measures, have been unavoidably injured. On contacting these individual men, I am first impressed by the fine type of young American manhood which makes up the employees on the project; and especially by their fine mental attitude and morale, and their coöperation with the medical staff in securing the greatest possible functional restoration from their injuries. With a total of more than eighteen thousand men employed on the project since its beginning, and with much of the early work in the Canyon of an extremely hazardous character, it is remarkable that there have been but seventy-four industrial deaths. This certainly speaks well for the safety measures employed.

The volume and diversity of medical and surgical work, with an average of two hundred patients a day in the outpatient department alone, is almost suggestive of a medical center in its opportunities for teaching, and in its value to medical observation and progress. Perhaps, from a surgical standpoint, the fracture work at the Boulder City Hospital will constitute the most valuable contribution on this subject of any fracture clinic of modern times. From the hazardous character of the work and the injuries resulting, many of these fractures are of the most serious and complicated types. Fifteen per cent of them are compounded and ofttimes there are multiple fractures in the same individual. In one case, if my memory serves me correctly, there were twenty-two separate and distinct fractures sustained by one individual in one accident, and it was my privilege to see this man living and making a good functional recovery. The use of local anesthesia in reductions of such a large number of cases is to be noted, as well as the relatively small number of open reductions which have been found necessary.

The anatomical end-results of these severe fracture cases, together with the minimum loss of time and permanent functional loss, will be one of the outstanding features of the Boulder Dam Hospital service when it is compiled and written into medical history.

It has been a pleasure to study this paper and a privilege to discuss it.

J. C. Geiger, M.D. (Director of Public Health, San Francisco).—In discussing this paper, opportunity is given to point out the advantages to be had by careful planning prior to the building of a new community. Boulder City might be looked upon as an ideal experiment in establishing a modern urban center.

Once such a community is established, it is then essential for those in charge to provide the necessary protection to public health through the medium of a competent health officer, and thus maintain a high health rating. On the other hand, it is very easy to allow conditions to manifest themselves so as to relegate the town into the category of a community with an average public health record, or even into the class

of those considered to have a poor record. Doctor Schofield's statements on the public health of the city and the excellent standards that he has been able to maintain, as reflected in the condition of the city today, are indicative of the health dividends to be expected from careful planning and proper control. Particular credit is due to those in charge of public health at Boulder City, when we consider the rapid increase in population until, at the present, the community is accommodating approximately double the maximum it was originally intended for. Aside from the usual problems of public health within this community, the health authorities have been confronted with the continual heavy influx of tourists from all parts of the world.

The water supply of this city is of exceptional interest from the standpoint of public health. During a visit to Boulder City I was quite interested in knowing just what was being done to Colorado River water to transform it into a potable supply. Inspection of the filtration plant afforded an occasion to observe the careful methods of treatment employed, and the concise control measures maintained through proper bacteriological and chemical examinations. Doctor Schofield's figures on the flourine content of the water are of exceptional interest and importance. His statements relative to the concern that has been expressed over the high flourine content, and the adverse remarks that have been made pertinent to the condition of the teeth of the children residing in the town, are very timely. As health officer, his observations of school children and contact with the dentists of the city allow him an opportunity to closely observe this phase of public health, and is thus able to be the better judge of the entire subject in his neighborhood.

Sewage disposal is in keeping with modern sanitary engineering and public health practices. The plant is of sufficient capacity to care for the needs of the present population, and is of desirable construction and design.

The milk supply presents itself as a problem of some significance in view of the excess summer temperatures. It is pleasing to note that the supply for the commissary of the Six Companies Inc. is produced on a ranch owned by that corporation, and comes entirely from tuberculin-tested cows. Such an arrangement allows very close supervision in exercising public health control measures over production and distribution of the milk for approximately one-sixth of the entire population. The absence of compulsory proper pasteurization is to be regretted, and could be considered a definite criticism of an otherwise perfect set-up for milk control.

On a project such as Bolder Dam, adequate housing for employees is always a problem of some magnitude. Unfortunately, in altogether too many instances this factor is not properly dealt with and adversely affects the health, moral and working ability of employees. I was particularly impressed with the accommodations for single men in the dormitories, and the desirable houses for married men and families. The buildings were well constructed, and equipped so as to allow maximum comfort for the climatic conditions.

While visiting the project one's attention is drawn to the safety measures in use, and the obedience to safety rules exercised by the workmen. The gigantic undertaking and the speed continually maintained leaves the casual observer with a feeling that employment here is of a very hazardous nature. Closer observation, however, discloses the many safety devices available, and the alertness of the employees to avoid accidents despite the casual manner and ease in which they go about their tasks. The enforcement of safety rules by competent foremen is unquestionably an agreeable and efficient set-up, but the employment of a safety engineer, or inspector, is very effective for daily contact with these foremen.

Medical examination of applicants for employment is very important. The low percentage rejected, as shown in this paper, in spite of the stringent examination, indicates a very high physical standard of men applying for work.

The industrial accident arrangement of this project is distinctive and unusual because of the involvement of two states. The hospital and staff, first-aid stations and ambulance service have been well planned and function efficiently. The medical services offered are of the highest type, and the complete equipment at hand guarantee to the workmen the best of care in case of sickness or injury. After considering the many different types of work at Boulder Dam, it is readily seen that the medical staff must be ready for any kind of emergency twenty-four hours a day. The ambulance service and first-aid stations afford treatment and hospital care to those injured at the dam site within the shortest possible time. The cost of hospitalization to the workmen is very reasonable, and the benefits derived fully compensate each man for the small amount invested.

The records maintained on industrial accidents will be of interest when the entire project is complete. The medical-legal controversies will undoubtedly establish many points without precedence, due to the question of dual State control. It is practically impossible to complete such an undertaking without having to deal with persons who are always anxious to derive benefits at the expense of the company for some chronic condition or for an injury received other than in line of employment; and it is surprising to me that the officials have not been confronted with a great many more such cases than they have already experienced. Good medical examination and complete records at the time of employment are of outstanding value in keeping such cases at a minimum.

In summarizing this discussion, we find that a new community has been established with a very modern public health and emergency set-up. The city has grown to double the maximum population originally intended, and an enviable public health standard has been maintained. One of the largest construction projects ever undertaken is well under way, and thirty-six hundred employees and many of their families are cared for. The problems of housing, food, sanitation, industrial hygiene, safety, first-aid, and hospitalization have been exceptionally well met. Doctor Schofield and his assistants are to be congratulated for the splendid record they have established as public health officials and in industrial medicine.

TRAUMATIC EPITHELIAL CYSTS*

By Laurence R. Taussig, M. D.
and
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San Francisco

Discussion *by Stanley O. Chambers, M.D., Los Angeles; Arne E. Ingels, M.D., San Francisco; James F. Rinehart, M.D., San Francisco.*

TRAUMATIC epithelial cysts have been seldom mentioned in the American literature before the recent report by Wien and Caro.[1] For this reason, and in order to stress their relative frequency, it is deemed worth while to review the subject briefly, and to report the cases seen and studied by us.

CLINICAL FEATURES

The lesions are round or oval swellings the color of the surrounding skin. They may vary in size up to one or two or more centimeters in diameter. On palpation they are firm and usually freely movable over the deeper tissues and beneath the overlying skin, which may show evidence of previous injury in the form of a scar. They are

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Fig. 1 (Case 12).—Traumatic epithelial cyst of thumb.

usually painless and only slightly tender on pressure, although injury or infection may alter both the appearance and the symptomatology. These cysts are most frequently encountered on the palms and grasping surfaces of the fingers, especially of the index finger. Sebaceous cysts closely resemble epidermoid cysts, both clinically and pathologically. The most important point in differentiating them is the fact that epithelial cysts occur in regions devoid of sebaceous glands and hair follicles. Other tumors, such as fibromas and xanthomas, may be distinguished by their greater firmness or typical color.

REVIEW OF THE LITERATURE

The summaries of Wörz [2] and of Pietzner,[3] reviewing fifty-five and seventy-three cases respectively, show that males (85 per cent) are affected more often than females, and individuals of the laboring classes more often than those whose hands are less constantly exposed to trauma. A definite history of injury to the area, such as incised, punctured, or contused wounds, splinters of wood, dog bite, etc., may be obtained in roughly 50 per cent of the cases (Wörz, 44 per cent. Pietzner, 59 per cent). According to Pietzner, the time of development may vary from a few months to as long as twenty-four years, which makes it apparent that trauma may have occurred preceding the development of some, and have been disregarded or forgotten during the long period of growth.

Excellent summaries of the theories and experimental evidence brought forth regarding the etiology of these lesions are found in the articles by Wien and Caro, Zimches,[4] and Behrens.[5] In 1890, Franke [6] advocated that these lesions resulted from the pinching off of epithelial pegs which continue to grow independently of the rest of the epidermis. Epithelial pearls are first formed, which by continued growth and central softening later become epidermoid cysts. Garré [7] (1894) elaborated the theory of traumatic origin which was previously suggested by Groş [8] and Reverdin,[9] and supported by the investigations of Schweninger,[10] Kaufmann,[11] and others. These authors had already shown that detached epithelium with or without its usual appendages, when buried in the deeper tissues, was capable of continued growth with the production of closed epithelium-lined cysts. Garré held that portions of the epidermis, which were detached by injury and buried in the subcutaneous tissue, were responsible for the appearance of these cysts. Recently Zimches, working experimentally with dogs, observed the development of epidermis-lined cysts following the burying into striated muscle of excised bits of epithelium, together with their underlying connective tissue, from the hairy skin, the nose, the mucosa of the cheek, and of the urinary bladder. Another possible origin is suggested by von Kugelgen,[12] Pels-Leusden,[13] F. A. Hesse,[14] and others, who produced cysts with epidermal lining by injecting various solutions, and burying foreign bodies such as magnesium disks, catgut, blood-clots, small gauze tampons, etc. Pels-Leusden held that the epithelialization about such foreign bodies proceeded from the ducts of the sweat glands and other appendages injured in the process, and not from the surface of epithelium. Absorption of the original foreign body may leave a cyst cavity filled only by the usual atheromatous material, cholesterol crystals, cast-off horn cells, and cellular débris.

In addition to the more common sites of origin on the hands, these lesions have been reported under various conditions, and in many different parts of the body. Zimches reports a case of epidermoid cyst developing in the scrotum of a man in whom an attempt was made to replace a defect in the tunica vaginalis by an epidermal graft. Neugebauer,[15] in an operation to free the musculospiral nerve from cicatricial compression, released the nerve and surrounded it by an epidermal graft. On healing, a sinus was formed which discharged atheromatous material and led to an imperfectly closed epithelial cyst. Martin [16] has reported two cases of epithelial cyst forming after operative removal of ingrown toe-nails. Hartley [17] reports a case of epidermoid cyst developing in the healing of a compound fracture of the skull, while Lexer [18] produced scar tissue containing epithelial cysts when he attempted to replace a defect in the



Fig. 2 (Case 2).—Low power microphotograph showing an early traumatic epithelial cyst with the wall thrown into ridges.

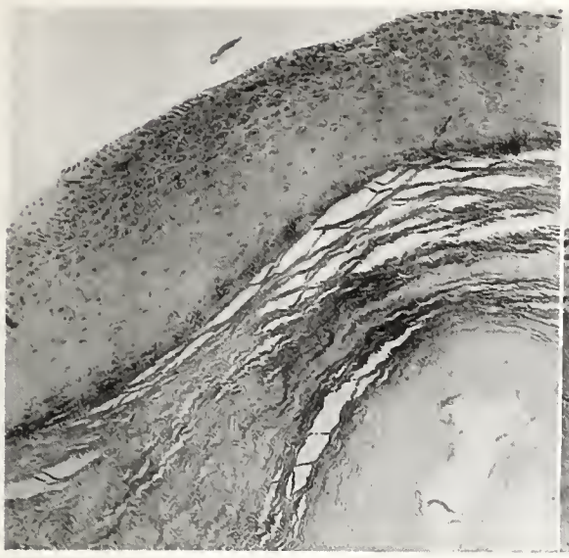


Fig. 3



Fig. 4

Fig. 3 (Case 8).—Microphotograph of wall of an epithelial cyst of long standing showing the presence of a basal layer, intercellular bridges and a granular layer.
Fig. 4.—Microphotograph of a section through the wall of a sebaceous cyst of the scalp.

dura mater with skin. F. Krauss [19] experimentally used pedicled skin-flaps to replace peritoneal defects, placing them with the epidermal surface outward, with the result that, in healing, numerous epithelial cysts were formed. Pribram and Finger [20] obtained the same results in using Tiersch grafts to replace defects in the serosa of the stomach wall. Zimches found epithelial cysts developing in the wall of the small intestine of the dog after using skin-strips as sutures experimentally in intestinal anastomosis. Goldzicher,[21] Masse,[22] Hosch,[23] and others, have reported cases of epithelial cysts developing in the iris, after penetrating wounds of the eyeball, and shown that they may arise experimentally after implanting nasal mucosa, bulbar conjunctiva, skin of the eyelid, etc., into the anterior chamber of the eye. It is interesting to note that Sutton [24] has called attention to trauma as an etiologic factor in the development of mucous cysts of the lips; and in the light of the present discussion it would seem likely that some of these lesions might well be "epithelial implantation" cysts. Epidermoid cysts are reported to have occurred in the scar following breast amputation.

Apparently, there is no unusual tendency for metaplasia to occur in the epithelium lining of these cysts, although Franke [25] has described cancerous degeneration in the "epidermoid" of the ball of the thumb, just as numerous writers have reported malignant degeneration in the walls of dermoids and sebaceous cysts. Benecke [26] has also called attention to the possibility of malignant changes in epidermoid, as well as in dermoid cysts.

REPORT OF CASES

During the past few years we have had the opportunity of studying twelve instances of epithelial cyst formation. In several cases the true nature of the lesion was only recognized on microscopical examination. One lesion has not as yet been removed, but the clinical diagnosis is so apparent that it is included in this series. A very brief clinical résumé of the cases and the pathological findings are given in the case reports which follow:

Case 1.—G., female. A pea-sized nodule had been present on the tip of the right elbow for many years. It was excised. On section a cyst was seen in the derma. The cyst wall consists of three or four layers of epithelial cells. A layer of cuboidal cells forms the outer surface of the wall. A granular layer is well marked on the inner surface. The cells are flattened and many dyskeratotic cells are present. Parakeratosis is not present.

* * *

Case 2.—B., male. A hazelnut-sized lesion developed following an injury three months before on the palmar surface of the base of the right thumb. There was a small area of ulceration at the vertex. Microscopic section shows a marked hypertrophy of epithelium, which is thrown into ridges with keratinization occurring inwardly toward the center of the lesion. Much of the keratinized substance in the center contains nuclei.

* * *

Case 3.—C., female, sixty-two years of age. A tumor the size of a pea had been present on the right side of the upper lip for two months. There was no history of trauma. It was excised. Microscopic section shows a central keratotic accellular mass presenting pearl formation. This is surrounded by keratotic material, in which some nuclei remain and a moderate leukocytic infiltrate. The cyst wall is of uneven thickness and consists of an average of ten layers of cells. Parakeratosis is to be seen in some areas and a well-marked granular layer in others. Angiomatous tissue is present between the cyst wall and the epidermis.

* * *

Case 4.—P., female, sixty-five years of age. A red, bean-sized fibrous mass was present on the buttock with a depressed scar in the center. It was excised. Microscopical examination showed a fibrous mass surrounding a small thin-walled cyst, the wall of which was made up of from two to four layers of flattened epithelial cells. The content of the cyst appears to be a lammellar mass of keratin without nuclei. No definite basal layer or granular layer is present. Intercellular bridges are not present.

* * *

Case 5.—T. M., female, fifty-one years of age. A pea-sized red cyst was removed from the outer surface of the right arm. Pathological examination shows a

cyst wall consisting of from four to eight layers of cells. The basal layer is not well marked, and the cells of the outer layers are flattened. In a few areas the granular layer is well marked. Intercellular bridges are not present. Dyskeratotic cells are numerous. Parakeratosis is not present.

Case 6.—M. S., male, sixty years of age. To the left of the anus was a mass the size of a chicken egg, which had been present for a number of years. This mass was incised and curetted on two occasions. On the second occasion, a thick capsule was scraped out. Section of the capsule shows the wall to consist of a thick layer of epithelial cells showing marked acanthosis. On the inner surface of the cyst there is marked keratosis with parakeratosis. The granular layer is well marked. Many dyskeratotic cells are seen.

Case 7.—R. McM., male, forty-three years of age. A lesion had been present on the edge of the ear for five or six years. Clinically it was an ear corn. Microscopic examination shows the surface epidermis to present hyperkeratosis and acanthosis. Under it is a layer of angiomatous structure. In one area there is a cyst which just about fills the field of the low-power objective. It is filled with degenerated cells. Three-quarters of the wall is made up of flattened epithelial cells, from two to six cells thick. In the thicker areas intercellular bridges are present. Many dyskeratotic cells are noted. One-quarter of the cyst wall is made up of endothelial hyperplasia with numerous new blood vessels.

Case 8.—L. van W., female, fifty years of age. A plantar wart was removed by curettage, and the base treated with trichloracetic acid. Four months later a painful callus was noted, and operation was undertaken to remove a presumed recurrent wart. A wen-like cyst was found and removed. On microscopic examination, the cyst wall is found to consist of layers of flattened cells varying from four to ten cells in thickness. The cyst content is lamellated and in some areas consists of parakeratotic cells. The granular layer is well marked. Cellular bridges are present, and the basal layer is well marked in the thicker portions of the cyst wall.

Case 9.—P., female, forty-eight years of age. A plantar wart was treated with x-ray. Three years later an apparent recurrence was operated and found to be a wen-like cyst. Sections were not made.

Case 10.—F., male, fifty-nine years of age. A thick callus had been present for eight months and had followed an injury with a nail. On paring the callus, a shiny cyst-like lesion was seen and the clinical diagnosis of traumatic epithelial cyst was made. It was removed. On section the cyst wall is seen to consist of markedly flattened cells. No intercellular bridges are to be seen, the granular layer is present and there is no parakeratosis. The cyst contents are lamellated. There are no dyskeratotic cells in the cyst wall.

Case 11.—D., male. A hazelnut-sized cystic lesion occurred on the palmar surface of the base of the right thumb. It had been present for a number of months. A clinical diagnosis of epithelial cyst was made. Section shows markedly flattened cells forming the cyst wall. Intercellular bridges are present in a few areas. Dyskeratotic cells are to be seen here and there. There is no parakeratosis and the basal cell layer is present in the thicker areas.

Case 12.—E. M., male, fifty-four years of age. A marble-sized lesion is present under the nail of the right thumb. The skin over the mass is a little pinker than the surrounding skin and is stretched. The tumor has the consistency of dough. There is no pain or discomfort except for the inconvenience due to the size of the lesion. It developed, following jamming the finger in a closing automobile door, six or seven years ago. It has not been treated.

COMMENT

It is interesting to note that 50 per cent of the twelve cases occurred in women. This is not in agreement with the figures of Wörz and of Pietzner, whose series were, however, much larger. Three of the lesions occurred on the plantar surface of the foot, and three on the palmar surface of the hand. Though a definite history of trauma was not obtained in many of the cases. The location of the lesions makes it probable that trauma played a part in their development.

PATHOLOGY

Microscopically, the condition consists of a cyst filled with keratin or cell detritus, and lined by epithelial cells more or less closely resembling those of the epidermis. We encountered two general types. The first was seen in relatively young lesions of a few months' duration. In this type the lining of the cyst was thrown into folds, and the keratotic material forming the contents of the cyst retained its nuclei to a considerable degree (parakeratosis). In addition, these early lesions showed some leukocytic infiltration indicating an infectious process as being partially responsible for the change that was taking place. The second type presented a smooth, firm cyst wall similar macroscopically to that of a sebaceous cyst. It differs from the sebaceous cyst histologically in that the cells tend to resemble those of the epidermis. Often the intercellular bridges are prominent in at least a portion of the wall. The granular layer is usually present in some areas. Dyskeratotic cells are frequently observed. In the case of a lesion of long standing, the microscopical picture of a sebaceous cyst and of an epithelial cyst may be so similar as to make the differentiation difficult without the clinical history.

TREATMENT

The treatment of epithelial cyst is the same as that of a sebaceous cyst. They can be readily dissected out under local anesthesia. There is no tendency toward recurrence, provided the entire sac is removed.

CONCLUSIONS

Traumatic epithelial cysts occur rather frequently on surfaces exposed to injury.

Trauma is probably the most important etiologic factor in the development of these lesions.

They are readily cured and seldom undergo malignant degeneration.

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DISCUSSION

Stanley O. Chambers, M.D. (1260 Roosevelt Building, Los Angeles).—To judge from the authors' comparatively large group of collected cases, traumatic epithelial cysts occur more frequently than the clinician is aware. This fact should lead to a more careful appraisal in suspected lesions in which identification would offer great simplification in the treatment of such a resistant and recurring lesion. Doctor Taussig has thoroughly reviewed the subject and added a large series of cases to a group of hitherto little considered pathologic entity.

Arne E. Ingels, M.D. (490 Post Street, San Francisco).—After having gone through the authors' literature references, and having seen the sections, which by courtesy were lent me, I am in the peculiar position of not knowing exactly what points are utilized in the differential diagnosis. As we know, the history of trauma is often questionable and overemphasized by the patient. The authors mention that the pathology is confusing at times and they comment mainly on the pathology of the wall of the cyst in traumatic cystic epithelioma, leaving most of the other aspects of the pathology out of the discussion. Schweninger (Reference No. 10) mentions, as one of the essential differential points, that the surrounding of the cystic wall should be devoid of epidermal appendages, such as hair follicles and sebaceous and sweat glands in a traumatic epithelial cyst. None of the sections show sufficient material of the surrounding tissue for such an estimation, and this differential point from sebaceous cysts is not mentioned in the pathology reports.

It would seem also that the different staining methods should have been utilized, such as fat stains, etc., as well as serial sections in the doubtful cases. The wall in some of the preserved cysts show the typical sebaceous cyst morphology with flattened cells in half of the wall; the other half (cut tangentially, ?) shows more epidermal character.

An interesting point for discussion is why implantation cysts should be devoid of sebaceous material in instances where hair follicles and sebaceous glands have been implanted with the epidermis; another is C. Garée's idea (Reference No. 7) that an implantation cyst may be formed from sweat glands. As long as the contents of the cysts by various authors is mentioned, yielding a mucin-like, serous, keratinous and fatty cholesterin content, differential possibilities present themselves as (1) epidermoid cysts in which the appendages play a deciding rôle; (2) sebaceous cysts with hair follicles and sebaceous glands and fat-staining material; (3) keratoma of Wilson-Kernohan with keratin-containing cysts; (4) synovial cysts; and (5) the epithelioma adenoids—syringoma—adenoma sebacée (Pringle) group, when only isolated large cysts are present. Worth mentioning also is cystic basal cell epithelioma.

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James F. Rinehart, M.D. (University of California Medical School, San Francisco).—Doctors Taussig and Allington have drawn our attention to a pathologic condition of considerable interest. The experimental and clinical evidence given would appear to establish beyond reasonable doubt that this type of cyst arises from fragments of squamous epithelium, displaced by trauma. The histopathologic picture is rather characteristic. The cyst lining is composed of stratified squamous epithelium. In most instances the epithelial layer is complete, showing a basal zone, a stratum granulosum, and a keratinized internal layer. The content is usually clearly recognized as desquamated epithelial cells not requiring any special histologic method of study. In some few of the cysts of very long standing, the character of the content may not be so easily identified. In such cases a special stain for kerato-hyalin may be of some value.

The lesion that perhaps would histologically be confused with this is the sebaceous cyst. As has been pointed out, the clinical distinction is made upon the history of trauma and the sites of occurrence. From a histopathologic point of view certain distinctions serve for differentiation. The epithelial lining of the sebaceous cyst is usually much thinner, and less characteristically squamous epithelium, and does not show the clear granulosal and other layers. Intercellular bridges are absent or less clearly defined. The content of the sebaceous cyst is more amorphous and may contain cholesterol crystals. It is not composed of desquamated epithelial cells as in the traumatic cyst.

The authors have refreshed our memory on the occurrence and genesis of an interesting and frequently unconsidered pathologic condition.

Doctor Taussig (Closing). — It is true, as Doctor Ingels has said, that the histologic differentiation between traumatic epithelial cyst and sebaceous cyst may be difficult at times, but I doubt that differential staining methods would be of much assistance in these particular cases. This conclusion is based on the fact that those in which difficulty arises are lesions of long standing, in which the cyst content would have lost any specific staining quality. In the earlier cases the wall is characteristic enough to make a diagnosis. It is true that the history of trauma is frequently doubtful, but the development of a cyst on the sole, palm, etc., certainly suggests a traumatic origin rather than a gland cyst. Since writing this paper, three patients have been observed with epithelial cysts. Two were on the sole, and one on the volar surface of the thumb. This emphasizes the fact that these lesions are not rare, and that more will be recognized if we are on the watch for them.

CARE OF INDIGENT SICK—BY THE SAN FERNANDO PLAN*

By P. Berman, M.D.
Los Angeles

THE so-called San Fernando Plan is a method of care for the indigent patients in the smaller communities in the county of Los Angeles, under the direction of the out-patient department of the County Hospital, whereby the patients are treated in the offices of the attending physicians instead of being sent to a county free clinic.

BEGINNING OF THE COUNTY HOSPITAL OUT-PATIENT SERVICE

The development of dispensary service in the county of Los Angeles, under the direction of the County Hospital, dates back to the year 1924 when Dr. R. G. Broderick and Mr. F. E. Chapman, the two experts employed by the Board of Supervisors to survey the needs for expansion of hospital facilities for the care of indigent sick in the county, recommended the establishment of a well-equipped out-patient department at the hospital, with branch dispensaries in the outlying districts. The out-patient service was started in the same year, and has grown rapidly to a very large department of the hospital. The recommendation to establish branch dispensaries in other communities was temporarily disregarded. The constantly increasing demands for medical care for indigents in the presence of the very limited facilities in the old buildings, and the problems connected with the planning for a new acute unit have kept the administration too busy to be able to give much consideration to the needs of the communities outside of Los Angeles.

THE OLD COUNTY HOSPITAL OVERCROWDED

The old County Hospital buildings on Mission Road, in the city of Los Angeles, meanwhile became overcrowded with patients. In due time, private clinics and, later, private hospitals, were requested to assist in the care of the overflow of patients in the County Hospital. The private clinics were paid at the rate of fifty cents per patient visit, plus additional cost of x-ray, laboratory, special medicine, etc. The private hospitals agreed to care for bed patients at a per diem rate approximating the actual cost of care of such patients in each institution.

DEVELOPMENT OF THE LOS ANGELES COUNTY HEALTH DEPARTMENT'S "HEALTH CENTERS"

During this time the County Health Department began to expand its facilities in the smaller communities and unincorporated areas in the county. Several health centers were established in various localities. These were primarily to serve as branch offices for the health department, and also to carry out a program of clinic service in preventive medicine. Some of these health centers were equipped for emergency care of sick and injured persons in the immediate vicinity of the clinics.

These health centers supplied a service which was greatly needed in the distant sections of the county where no other free clinics were in existence. To meet the demands for medical aid in the various smaller communities, these clinics have gradually widened their scope of activity and have finally included in each center a well-developed dispensary, with many departments similar to those in operation in the out-patient department at the County Hospital. The service, however, in the curative clinics (in contradistinction to the preventive medical work) was limited in many respects. The health officer was unable to dispense certain drugs and medical supplies, which were usually provided free of charge at the County Hospital out-patient department. Not all health centers maintained clinics in some of the specialties or could do certain diagnostic, x-ray and laboratory procedures. In the smaller centers, x-ray work was limited to certain days of the week, thus restricting emergency service. Many patients had to be referred to the County Hospital in Los Angeles from distant parts of the county.

CURATIVE CLINICS IN COUNTY HEALTH DEPARTMENT'S "HEALTH CENTERS" RULED ILLEGAL

In July, 1931, the County Counsel rendered an opinion to the Board of Supervisors to the effect that the health department is not authorized legally to render medical aid to persons coming under the provision of the Pauper Act, except in cases where treatment is needed to prevent the spread of contagious disease.

Early in 1932 the Bureau of Efficiency of the county of Los Angeles, taking into consideration the above opinion and also the result of an extensive survey of all departments at the General Hospital, recommended to the Board of Supervisors, with a view of eliminating duplication and overlapping of medical services in the county, and to increase general efficiency, that all activities in connection with the care of indigent sick in the curative clinics be turned over to the Department of Charities, where they legally belong.

COUNTY HOSPITAL TAKES OVER THE "HEALTH CENTER" CURATIVE CLINICS

The Los Angeles County Health Department immediately began to curtail its services in the

* From the office of the medical director of the Los Angeles County Hospital.
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curative clinics in the various health centers. By the end of the fiscal year 1931-1932, few such clinics remained in full operation. In June, 1932, all the curative clinics, including the emergency stations in the health centers, were ordered transferred from the jurisdiction of the health department to that of the Department of Charities. In due time the County Hospital was requested to organize the clinics and operate them as a part of its out-patient service.

REORGANIZATION OF "HEALTH CENTER" ATTENDING STAFFS

The existing attending staff was then reorganized for each health center. The physicians all became members of the attending staff of the County Hospital. A representative of the attending staffs of all the curative clinics was appointed as a member of the Medical Advisory Board of the hospital. A medical social service worker from the hospital staff was placed in each clinic. Instructions were issued, making the policies in the clinics in all respects, including the method of admission of patients, conform with those in effect at the County Hospital. An interne from the hospital house staff was assigned to each clinic.

IMMEDIATE RESULTS OF THE ADMINISTRATIVE CHANGE

The number of patients in the various clinics immediately began to increase, as it was possible now to transfer patients freely from the out-patient department in the hospital to various clinics in the outlying districts. A system of close supervision of the work in the clinics was inaugurated. Many conferences were held with members of the various attending staffs, nurses and social service workers, and many changes were made in methods, procedures, and policies. It was felt that the service to the indigent sick in the smaller communities was materially improved.

The administration of the hospital, however, was not entirely satisfied. There were many difficulties which we expected to overcome in the beginning when the service was taken over, but which we were unable to iron out after the first few months. The ordinary faults of the small, detached clinic, not immediately connected with a hospital, were augmented by the fact that close supervision at a distance was difficult.

Patients were making too many visits to the clinics. It was felt that quite often they were seen by the interne without adequate supervision from the attending men. Patients had to wait, sometimes for hours, to see a certain physician, and then find that the particular physician could not come to the clinic on that day.

Emergency service rendered in the smaller communities was too expensive. It was found that very few real emergencies were treated in any of the emergency clinics. However, a twenty-four-hour schedule for seven days a week had to be maintained in each place. In some instances this seemed to be an especially extravagant arrangement, when not very far from the health center a well-equipped, private hospital was in existence, where an adequate twenty-four-hour a day service was maintained, where emergency aid could be secured at any time, and where the patient could remain after the first treatment and not have to be transferred to some other hospital. This was especially obvious when it was found that most of these private hospitals already possess, or could easily secure, a contract with the County Hospital to take care of patients in an emergency.

LATER RESULTS OF THE CHANGE IN PROCEDURE

Physicians, after the first few months of service under the jurisdiction of the County Hospital, began to object to the fact that too much time was required of each man in the clinic and that, although they were members of the attending staff of the hospital, they could not avail themselves of the privileges and benefits of staff membership. The fact was also stressed that the conditions usually treated at the clinics are rarely of any special clinical interest to the physician, in comparison with the work done by members of the attending staff at the hospital.

It was claimed that during this "depression," when incomes have been greatly reduced, physicians should not be required to leave their office for half a day once or twice a week to attend to County patients, without compensation. It was shown that some of them had actually suffered a loss in their private practice by being out of their offices on their clinic days.

DEVELOPMENT OF THE "SAN FERNANDO PLAN"

From the many plans advanced to help the above situation, one was decided upon, as a possible remedy, in July, 1933. This became known later as the San Fernando Plan. It was to be a radical departure from the accepted method of free medical care for indigent patients, and met with many objections from various quarters. However, after frequent meetings and discussions with county officials, it was agreed to put this plan on trial in the city of San Fernando for a period of ninety days.

San Fernando is a small community about twenty-five miles from the city of Los Angeles, where the first health center was built in 1926 by the County Health Department. It had a well-equipped emergency station, including several hospital beds; it was staffed by a small number of attending physicians and had been functioning as a part of the hospital out-patient department for about a year. This clinic was especially fitted for the experiment on account of its comparatively small size, the small staff, and the distance from Los Angeles.

The plan in general was to discontinue sending patients to the health center for treatment, and to send them instead to the offices of the various physicians on the staff, and to reimburse these physicians for the use of their offices, instruments, nursing care, incidentals, etc., at the rate of fifty cents per patient visit. It simply meant the transfer of the greater part of the expense of overhead in the county clinics to the physicians' offices, and to pay the physicians at approximately the actual

cost of this service. A precedent for a similar arrangement had existed in the county of Los Angeles for many years whereby a certain class of patients from the out-patient department were referred to private clinics. These clinics were paid at the rate of fifty cents per patient visit, which was considered to be approximately the cost of general overhead in the clinic.

HOW THE PHYSICIANS WERE RECOMPENSED

In July, 1933, an ordinance was adopted by the Board of Supervisors permitting the General Hospital to employ one hundred physicians as employees of the hospital, without pay, to take care of indigent patients in their offices, the hospital to reimburse these physicians for the use of their offices, instruments, nursing care, and incidentals at the rate of fifty cents per patient visit, and also for x-ray, laboratory, and special treatments at approximately the actual cost of such services.

The same ordinance also provided that these physicians may be paid by the county for visits to indigent patients' homes at the rate of $1.50 per visit, plus mileage at the regular rate paid County employees for mileage when their own cars are used.

The hospital was ordered to put the plan immediately into effect, and accordingly the following arrangements were made with the clinics in the city of San Fernando, beginning August 1, 1933:

All employees of the hospital, including the nurses, interne and other help, were removed from the clinics and ordered back to the County Hospital. This did not increase our personnel at the hospital, as a certain turnover of employees is expected each month. The few employees from the clinics could easily be absorbed.

The medical social service worker and her clerical assistant were the only ones left in the clinic representing the County Hospital.

The emergency station in the health center was closed. The local police authorities and other interested agencies were notified to bring patients who need emergency care to a designated private hospital.

OUTLINE OF THE METHOD OF MEDICAL CARE

The following method of the care of clinic patients was put into effect:

New applicants are seen by the medical social worker in the clinic as was done formerly; their financial status is carefully investigated and, if found to be eligible for care, they are referred to the office of one of the physicians on the attending staff.

Persons not eligible for care are referred, as formerly, to the proper agency where such care can be obtained. Those able to pay for private care are given names of private physicians. When in doubt the medical social worker refers the patient to the physician's office for examination, and consults with the physician as to further care.

In the selection of a physician the patients are assigned to the former family physician whenever possible; also members of one family are all sent to the same physician whenever advisable.

The physician is instructed to return a copy of his records of the case to the medical social worker after the patient's first visit. The new patient may then be permitted to continue to receive care at the doctor's office for four more visits, if needed. After the fifth visit the patient is sent back to the medical social worker for a recheck. If continuation of treatment is recommended by the physician, and the patient is still eligible for care, he is given authorization for five more visits.

If consultation in a case becomes necessary, the patient is sent to a consultant, who also is paid fifty cents for the use of his office, etc.

A consultant must have concurred in the diagnosis before a major operation is decided upon. Such a patient is sent to the County Hospital in Los Angeles, if the operation is not in the nature of emergency treatment; in emergencies the local private hospitals are available for use. The County Hospital pays for the service in the private institution at approximately actual cost.

The attending staff takes care of county patients in contract private hospitals without compensation, as they do of the patients in the County Hospital.

An arrangement is made with one or several local drug stores where patients obtain drugs and medication prescribed by the staff physicians. Stock preparations used in the out-patient department of the County Hospital are kept in these drug stores, and are dispensed by the druggists on prescription.

When indigent patients require a physician's service in their homes, one of these physicians on the clinic staff may make a home visit and submit his bill for $1.50 per visit, plus mileage.

EACH LOCAL STAFF HAS AN EXECUTIVE COMMITTEE

An executive committee in each local attending staff is organized to supervise all activities in the clinics. It consists of the chairman, secretary, one other member of the staff, the social service worker, and the assistant medical director in charge of the clinics.

This committee passes on all matters of policy in the local clinic, investigates complaints, and reports to the medical director at the County Hospital. It also acts as a membership committee, making recommendations regarding physicians who desire to become members of the staff. It also recommends disciplinary measures to be taken against individual members of the staff when necessary.

ADVISORY COUNCIL OF ALL CURATIVE CLINICS

There is, too, an advisory council of the curative clinics, consisting of the chairmen of all the executive committees, who are also chairmen of their respective staffs. The director of the hospital social service department, the medical director and his assistant at the County Hospital, are ex-officio members. This advisory council makes recommendations in matters of policy which concern all curative clinics in the county. It also acts as a body to which appeals may be taken from the

TABLE 1.—*Statistical Report for the San Fernando District Only*

	*July, 1932 to June, 1933 Inclusive	†Aug. 1933 to July, 1934 Inclusive
Total cost of operation	$13,495.45	$20,210.31
Average cost per visit	1.07	.995
Total amount paid doctors		9,202.73
Total number of visits	12,621	20,306

* Prior to San Fernando Plan.
† During operation of San Fernando Plan.

decision of the local committees. One of the members of this advisory council is annually elected as a member of the advisory board of the attending staff of the hospital.

RESULTS AT THE END OF NINETY DAYS

This plan, after being in operation for ninety days in the city of San Fernando, showed the following advantages:

Patients are apparently receiving better medical attention and their care is supervised more closely by members of the attending staff. There is much greater interest shown by the physicians in their patients. There is close coöperation with the medical social worker in transmitting recommendations, and seeing that necessary treatment is carried out.

A number of applicants in the clinics have become private patients of the physicians to whom they were sent for care.

The so-called "clinic shoppers" and those who like to go to the clinic for its "social" value do not care to go to the physicians' offices. In fact, such cases are promptly discharged by a physician after the first or second visit, and are taken off our lists.

Patients do not have to wait for hours in the clinics, but are taken care of in the same manner as private patients in doctors' offices.

Emergency cases are given prompt care in the private hospitals. A great percentage of such cases become private patients of the attending physician, thus greatly reducing the cost to the county.

Severely injured patients can remain in the hospital, and do not have to be transported to another institution soon after an operation.

The large number of patients who have swelled our clinics in the last two years, and who do not belong to the ordinary pauper class but are temporarily victims of the "depression," are not sent to a public clinic but are placed in the office of a physician. These patients appreciate the privilege of going to a private doctor's office. They will probably continue with the same physician as private patients when general conditions improve.

A certain amount of money was actually saved by the county.

The difficulties of this plan are the ordinary difficulties encountered when a new method of care of a large number of indigent patients is put into effect.

One of our problems is to teach a large group of physicians to practice medicine in accordance with hospital methods. Many meetings with the various staffs have been taken up by discussions of what to prescribe and how to prescribe. Physicians occasionally insist on using costly proprietary drugs when similar official preparations could be used at very little expense.

The keeping of proper records and the making of necessary reports by the various members of the staff is another problem with which some of the physicians have difficulties.

The supervision of the laboratory procedures in the various doctors' offices is not an easy matter, but is working out well in the last few months. Physicians have learned that they cannot request more laboratory work for these indigent patients than they would for their own private patients.

Occasionally a physician has to be especially supervised in the methods he is using in taking care of our patients in his office.

Complaints from patients are practically nil; in fact the only complaint that has reached my office in the last several months was from patients who claim that they miss the "social" side of the clinic.

After the trial period of ninety days in San Fernando, the Board of Supervisors ordered the hospital to extend the service in accordance with this plan to several other health centers in the county. At the present time, eight such clinics are in operation in the county of Los Angeles. Plans are being made to extend this plan county-wide to cover all the smaller communities.

It is the opinion of those who have kept in close touch with activities of the various clinics in the Los Angeles County Out-Patient Department for the last several years, that, with careful supervision, the San Fernando Plan will prove a success and a great improvement over the old method of caring for the indigent sick by the county of Los Angeles.

COMMENTS ON LATER EXPERIENCES UNDER THE SAN FERNANDO PLAN

Since this paper was read at the last meeting of the California State Medical Association, the San Fernando Plan was extended to include all sections of the county of Los Angeles, except the cities of Los Angeles, Pasadena, and Alhambra. The various districts were added, one at a time, during the last several months. It is too early to give a comprehensive report covering all the services at the present time. I am including a few figures for the district of San Fernando from August, 1933, to August, 1934. The plan has been in operation in this community for more than a

TABLE 2.—*Statistical Report for All Clinics in Operation Under the San Fernando Plan*

	**June, 1934 Only	‡Sept., 1934 Only
Total cost of operation	$21,569.66	$22,770.02
Average cost per visit	1.01	1.02
Total amount paid to doctors	7,867.08	9,122.28
Average amount paid to each doctor	38.75	21.17
Total number of visits	21,304	22,299
Total number of doctors who sent bills	203	431

** The last month of fiscal year before new districts were added. Ten districts in operation, including two not on the San Fernando Plan.
‡ Thirteen districts in operation, including one not on the San Fernando Plan.

year without many changes in procedure. For comparison, I am including also a brief report for the year 1932-1933 for the clinics in San Fernando; that is the year just before the new plan was put into effect. Some of the cost figures are only approximate, as it is difficult to segregate general costs in the hospital in some of the items included.

The brief statistical report covering all sections served by the San Fernando Plan is given only for the month of June, 1934, and for the month of September, 1934.

It is interesting to note that the cost per patient per visit, including drugs, laboratory service, dental work, special treatments, social service, etc., remains about $1. This is slightly less than the cost per patient visit in some of the clinics before the plan was put into operation. The list of fees for laboratory, x-ray, and special services was prepared and approved by the advisory council as a tentative schedule. The fees for the various services are changed and readjusted continuously to meet the conditions in the various districts.

The original plan of the care of patients in the doctors' offices has been adhered to, but some of the details have been modified in the last few months.

Laboratory and x-ray work are now concentrated in the offices of one or two physicians in each district. In some instances the service is being rotated every six months among the members of the staff interested in this work. Physicians who do laboratory work for the district are not allowed to have patients for treatment at the same time.

The fee for the home visit, which was originally $1.50 plus mileage, was changed to $1.75 without mileage. This home-call service has been administered from the beginning by another bureau in the Department of Charities.

Los Angeles County Hospital,
1200 North State Street.

ONE THOUSAND CONSECUTIVE DELIVERIES IN PRIVATE PRACTICE—A CRITICAL STUDY*

By Donald A. Dallas, M. D.
San Francisco

Discussion *by John Vruwink, M.D., Los Angeles; Frederic M. Loomis, M.D., Oakland; Donald G. Tollefson, M.D., Los Angeles.*

THIS study is based on one thousand consecutive deliveries occurring in the private practice of Dr. Henry A. Stephenson and myself. The period studied began on July 28, 1929, at the time I became associated with him. It is composed entirely of patients who came to us for obstetrical care, and does not include any consultation cases, or cases delivered for other obstetricians in their absence. It does include a number of our patients delivered for us by other obstetricians when neither of us was available.

* From the department of obstetrics and gynecology, School of Medicine, Stanford University.

Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30–May 3, 1934.

PURPOSE OF THIS STUDY

The study was undertaken with the idea of its being a thoroughly critical check-up of the methods we had been using in our obstetrical practice. As will be evident shortly, our method of delivery in our obstetrical cases is largely an operative one. A minimal amount of analgesic drugs in the first stage, and a short second stage of labor, are basic principles in our work. Gas and oxygen are given during the entire second stage to all patients. With most of the multiparous, and a few of the primiparous patients, gas and oxygen mixture is begun before full dilatation of the cervix. This procedure often enables us to conduct the labor without the aid of powerful analgesic agents. In the primiparous patients in this series, the second stage of labor averaged about forty-five minutes. Less than a fourth of the patients in the whole series were given morphin during the first stage, and in less than one twentieth was Gwathmey's method used. It is obvious from the above statements that most of our primiparous patients were delivered by forceps. Many of the complications of pregnancy are also treated by operative means. Five out of twenty-three low reserve kidney cases, eighteen out of twenty preeclamptic cases, five out of eight chronic nephritic patients, and all of our three eclampsia patients were delivered by cesarean section. This method of delivery is also used frequently in treating placenta previa and premature separation of the normally implanted placenta.

An idea of the character of our system of delivery in our obstetrical patients is evident from the foregoing statements. This series of deliveries is composed of 611 primiparous patients and 389 multiparous patients. Of these, 829 came to us before the fifth month of pregnancy and had what I would call very good prenatal care; 154 came to us after the fifth month, and therefore had only fair prenatal care; while seventeen patients came in the last month and had poor prenatal care.

TYPES OF THE CLINICAL MATERIAL

We are fortunate in having a practice composed largely of healthy American stock, and therefore had few deformed pelves with which to contend. From our routine office measurements, 790 pelves were called normal, and 158 generally contracted. There were two generally contracted flat, five simple flat, one funnel, one justo major and one deformed pelvis with ankylosis of the hip joint.

The presentation and position of the babies were recorded in most instances. Of these, 548 babies were in anterior, and 381 in posterior positions, twenty-seven presented by the breech,

Table 1.—*Types of Pelves*

Normal	790	or 79	per cent
Generally contracted	158	or 15.8	per cent
Simple flat	5	or 0.5	per cent
Generally contracted flat	2	or 0.2	per cent
Funnel	1	or 0.1	per cent
Justo major	1	or 0.1	per cent
Ankylosed hip with deformity	1	or 0.1	per cent
Not recorded	42	or 4.2	per cent
	1,000	or 100	per cent

TABLE 2.—*Position and Presentation*

Anterior	548 or 54.8 per cent
Posterior	381 or 38.1 per cent
Breech	27 or 2.7 per cent
Others	2 or 0.2 per cent
Unknown	42 or 4.2 per cent

and there were two compound presentations. No record was made in forty-two instances. There were undoubtedly more posterior positions than our records show, as many of the multiparous patients were not seen until the head was on the perineum in the anterior position, and undoubtedly a large number of these babies had entered the pelvic inlet in the posterior position and rotated anteriorly. I believe that the incidence of anterior and posterior positions is about the same.

Of the 611 primiparous patients, 102 or 16.7 per cent, and 258 or 66.3 per cent, of the 389 multiparous patients were delivered spontaneously. Three hundred ninety-three low forceps, eighty-three mid forceps and three high forceps operations were done. There were seven versions and extractions. One hundred nineteen low cervical, eight classical and seven porro cesarean sections were done. Excluding twenty breech extractions, this gives a total of 620 operative deliveries, an incidence of 62 per cent. Four hundred sixty-three episiotomies were done, an incidence of 53.4 per cent of those were delivered through the natural passages.

This relatively high operative ratio has, we feel, saved the lives of many babies and a few mothers, that otherwise might have been lost.

CESAREAN SECTION

Cesarean section occupies a large place in our obstetrical practice. A total of 134 or 13.4 per cent of the one thousand deliveries were accomplished by this operative procedure.

Because of pelvic dystocia, 44 cesarean sections were done. The duration of labor in these patients varied from three hours, in the shortest, to forty-two hours, in the longest, and from no dilatation to full dilatation of the cervix for two and a half hours. Many of these patients had a thorough test of labor, and cesarean section was done as the risk to the baby or the mother was too great for us to attempt delivery from below.

Out of a total of fifty-four toxemia patients, twenty-five were delivered by cesarean section. Our policy, in a general way, has been to treat our toxic patients medically as long as, in our opinion, it seemed in the best interest of the mother and the child. It is a well-known fact that toxemia in the mother definitely affects the baby, and that death of the fetus in utero is of common occurrence in long-continued toxic states. It is also well known that toxemia, in a large percentage of cases, definitely and permanently damages that mother's kidneys, and results in chronic nephritis which shortens her life expectancy by many years. The treatment of our toxic cases is always carried out with these two well-known facts in mind, and consequently the medical treatment of these patients varies from a few hours to several weeks. Induction of labor is attempted in these patients only when the life of the baby or the health of the mother is not jeopardized by the delay. Otherwise cesarean section is done at the most favorable time.

TABLE 3.—*Types of Delivery*

Spontaneous primiparae	102 or 16.7 per cent
Spontaneous multiparae	258 or 66.3 per cent
Low forceps	393
Mid forceps	83
High forceps	3
Breech extraction	20
Version and extraction	7
Low cervical cesarean sections	119
Classical cesarean sections	8
Cesarean sections with hysterectomy	7
Total operative deliveries	620

Twenty-four repeat cesarean sections were done. We feel that "once a cesarean, always a cesarean" is a good policy, with the exception of those rare cases when the patient has had a normal delivery preceding her first cesarean section.

Twenty elective cesarean sections were performed. This group was composed of patients in whom it seemed obvious that cesarean section was the method of choice for the delivery.

Five cesarean sections were done on patients who had had previous extensive repair operations. This indication for cesarean section is, I think, well founded, and is accepted by most experienced obstetricians as the method of choice for subsequent deliveries.

Three cesarean sections were done after attempted forceps deliveries. This procedure is one fraught with danger, if the technique of the accoucheur in the delivery room is not perfect, and it should not be attempted by the occasional obstetrician. The convalescence in these three patients was uneventful, and the babies were normal.

Three out of five cases of premature separation of the normally implanted placenta were delivered by cesarean section. The operation is not indicated in patients where labor is advancing satisfactorily, and the baby is dead. However, it is frequently a life-saving operation for both mother and child, and is one of the most satisfactory procedures in obstetrics.

Two cesarean sections were done in cases of breech presentation after a test of labor. Two out of five cases of placenta previa were delivered by cesarean section. Both mothers and babies were dismissed from us alive and well. We now feel that low cesarean section is the method of choice in dealing with placenta previa of marked degree.

Two cesarean sections were done because the baby showed evidence of distress during the first stage of labor. The fetal heart rate dropped to forty per minute in one and to sixty in the other. The first patient was a multipara who had had a difficult first labor with a third-degree laceration. The baby's head was floating and the cervix closed. The second was a primipara with the head floating, and 3 centimeters dilatation of the cervix. These patients were operated on as soon as possible and living babies obtained. Both babies were markedly asphyxiated, and I feel owe

TABLE 4.—*Indications for Cesarean Section*

Pelvic dystocia	44
Toxemia	25
Repeat	24
Elective	20
Previous repair	5
After attempted forceps	3
Premature separation	3
Breech after test of labor	2
Placenta previa	2
Baby in distress	2
Cervical dystocia	1
Compound presentation	1
For sterilization	1
Others	1
Total	134

Deaths, 2 or 1.49 per cent.

their lives to cesarean section. Labor was induced in one of the patients by rupture of the membranes. I will later discuss two other cases in which this method of inducing labor was employed with unhappy results.

One cesarean section was done for cervical dystocia after twenty-four hours of labor, one for compound presentation in a twin pregnancy, and one for sterilization.

BREECH PRESENTATION

Twenty-seven babies presented by the breech at the time of delivery. External version had been unsuccessful in a number of these. We have not followed any definite predetermined course in the management of labor in breech presentation, and have treated each case as an individual.

Elective cesarean section was done three times. This group consisted of a forty-one-year-old primipara at term, a primipara with a generally contracted pelvis at term, and a primipara with a normal pelvis, whose baby weighed nine pounds one ounce.

Two low cesarean sections were done on primiparous patients when, after a moderate test of labor, the breech remained above the pelvic inlet. One low cesarean section was done at seven and one-half months for preëclamptic toxemia. The baby lived, although it weighed only four pounds.

One cesarean section and myomectomy was done at seven months on a patient whose membranes had ruptured prematurely, and whose uterus contained multiple large fibro myomata. The baby weighed only three pounds and did not survive.

Twenty breech extractions were done. The second stage of labor in these cases varied from five minutes to three hours. The duration of the second stage depended entirely upon the progress being made, and the general condition of the baby as evidenced by its heart sounds. Two of the babies were still-born and macerated. One was still-born in a central placenta previa, in which a Voorhees bag was used for control of hemorrhage and the induction of labor. There were two babies whose congenital malformations were incompatible with life. None of the babies died of birth injuries—the only injury of any consequence being a fractured clavicle, which healed without deformity.

There was no maternity mortality in the breech group.

VERSIONS AND EXTRACTIONS

Podalic version and extraction was used only seven times in the one thousand deliveries studied. We resort to this operation with great reluctance, and only when all other means of delivery are either contraindicated or have been attempted unsuccessfully. The extremely high fetal mortality, and the high incidence of serious injury to both baby and mother, are too well known and appreciated to require further discussion here.

The operation was done three times after failure with forceps, twice in central placenta previa, once for prolapse of the umbilical cord and once when the fetal heart rate dropped to seventy-two per minute after artificial rupture of the membranes in a multiparous patient whose cervix was dilated 7 centimeters. None of the mothers died. Two of the babies died shortly after delivery, and one was a macerated fetus.

POSTPARTUM COMPLICATIONS

Seven patients in the entire series developed breast abscesses. These were opened by one or more radial incisions, and the abscess cavities packed with iodoform gauze. Seventeen patients developed pyelitis postpartum. One case was extremely severe, and required hospitalization for a period of eight weeks. There were eight cases of thrombophlebitis of varying degrees of severity. Two of these cases were bilateral, and required bed rest for two months.

Postpartum Hemorrhage.—There were twenty-three cases of postpartum hemorrhage. The uterus and vagina in all but one of these patients were packed with dry gauze. This method of controlling postpartum hemorrhage has proved entirely satisfactory, and we do not hesitate to pack the uterus if the amount of bleeding is at all excessive.

OPERATIONS DURING PREGNANCY

Four laparotomies were performed during pregnancy in this series of patients. Two myomectomies were done: one at two months and the second at five months, both for torsion of the pedicle. Both pregnancies continued normally. One chole cystectomy and appendectomy was done by a colleague at four weeks, he being unaware of the pregnancy at the time. The pregnancy continued normally. One appendectomy for acute appendicitis and cesarean section was done at seven and a half months. The baby did not survive, and I will discuss this case under fetal mortality.

MATERNAL MORTALITY

Three patients out of the one thousand in this series died, 0.3 per cent.

CASE 1.—The first can be dismissed with a brief discussion, as she had a subacute bacterial endocarditis with positive blood culture of streptococcus viridans six weeks before delivery. Her labor was entirely uneventful and her convalescence normal except for her endocarditis. She died fifteen days postpartum, apparently from a cerebral embolus which detached itself from a heart valve. This was not an obstetrical death in any sense of the term, but must be included

in our mortality rate. Cultures were taken from the umbilical cord blood and showed no growth. The baby was normal.

* * *

Case 2.—The second patient was a multipara whose pregnancy had been entirely normal for seven and a half months. She developed an acute toxemia with hypertension and edema with almost complete anuria. After twenty-four hours of medical treatment, she was delivered by classical cesarean section of a normal three and a half pound baby. The operation was entirely satisfactory. Her blood pressure, however, at the end of the operation was 50/35. She was given 500 cubic centimeters of 10 per cent glucose intravenously, and her blood pressure rose to 112/70. She did not seem to be in shock. After three hours, however, her systolic pressure was 85. She was given 600 cubic centimeters of 25 per cent glucose. Her blood pressure rose to 130 systolic, but fell within an hour to 65. Then 700 cubic centimeters of whole blood was given and her blood pressure rose to 110/80, and her condition seemed quite satisfactory. The first day postoperative her blood pressure remained about 100 throughout the day. Her general condition was excellent, except for a very rapid heart rate. Her urinary output was more than twenty-five ounces. The second day postoperative her blood pressure fell to 50/37, the pulse was rapid, but she was perfectly clear mentally, and no great anxiety was felt about her general condition. Medical consultation was obtained and a diagnosis of paroxysmal tachycardia was made. However, the patient's general condition became gradually worse, and in spite of intravenous glucose she died. Autopsy was obtained and sections of liver showed a marked increase in round cells, numerous large areas of necrosis about the central veins and some extravasation of blood into the parenchyma, with resulting disappearance of the liver cells in these areas.

* * *

Case 3.—The third patient was a primipara whose pregnancy was entirely normal. Her pelvic measurements were ample. Her labor began at 2 p. m. Examination on admission to the hospital showed that the baby's head was floating in L. O. P., the membranes were intact, the pains not particularly strong. After about eight hours, however, the pains became very strong and she was given morphin sulphate one-sixth grain with considerable relief. After forty hours of labor the cervix was almost fully dilated, the head still floating, and the membranes were ruptured artificially. The head did not descend, and as forceps on the floating head was considered inadvisable, low cesarean section was done. We used the transverse incision in the lower uterine segment in this operation, and the bleeding was rather more than usual. This was controlled, however, without difficulty. At the end of the operation the anesthetist reported the patient's pulse was not good, and she was given 500 cubic centimeters of 10 per cent glucose solution while the abdomen was being closed. There was no improvement in the patient's general condition from this intravenous therapy. Her respiratory rate was very slow, and she was given carbon dioxid and oxygen with some improvement. She was transfused with 700 cubic centimeters of citrated blood without any appreciable improvement. She did not seem to be in shock at any time, and while preparations were being made for a second transfusion her respirations stopped. This test of labor was undoubtedly too long, and had the cesarean section been done earlier this patient's life might have been saved.

COMMENT

We have had under our care, of course, a great many other pregnant women during the period studied. This group includes ectopic pregnancies, therapeutic abortions, many spontaneous abortions complete and incomplete. No deaths have occurred in this group. Had these patients been included in our study, our maternal mortality rate would be appreciably reduced.

It is extremely difficult to compare statistics and draw conclusions when the data are from entirely different sources, and conditions are not exactly the same. However, a maternal mortality of three per one thousand deliveries is approximately one-half that reported in the United States registration area, New York City, and for New York State, excluding New York City, and in most of the other recently reported statistics.

There was no puerperal septicemia in the series, despite the high operative incidence, and the fact that all of our patients were delivered in general hospitals.

We feel that the ultimate health of a great majority of our patients is better for having been delivered under this general system of obstetrical practice. This applies especially to the toxic patients whose kidneys have not been damaged during a protracted period of medical treatment, and to those patients exhibiting pelvic dystocia whether due to actual cephalo pelvic disproportion, or only to relatively slight disproportion complicated by faulty fetal position. The first group needs no discussion, as the facts are well known. The poor health of the second group, however, is not generally appreciated; but every gynecologist and internist sees many of these semi-invalids whose disability began with a protracted labor and difficult instrumental delivery.

Table 5.—*Unavoidable Fetal and Neonatal Mortality*

1.	Stillborn macerated. True knot in cord. Died one week before delivery.
2.	Stillborn macerated. One-third of placenta white infarct. No other cause found.
3.	Stillborn macerated. At seven months, Wassermann negative. No cause found.
4.	Stillborn macerated. At term. No cause found
5.	Stillborn macerated. At term. Central placenta previa.
6.	Stillborn macerated. At term. Placenta one-third normal size.
7.	Stillborn macerated. At seven months. Toxemia.
8.	Stillborn macerated. One week overdue. No cause found.
9.	Stillborn macerated. Wassermann negative. No cause found.
10.	Premature separation. Immediate cesarean section—stillborn.
11.	Premature separation. Baby dead on admission to hospital. Spontaneous delivery
12.	Prolapse umbilical cord—baby dead.
13.	Monster.
14.	Monster.
15.	Monster.
16.	Monster.
17.	Premature rupture of membranes at seven months. Baby died of prematurity.
18.	Premature rupture of membranes at seven months. Baby died of prematurity.
19.	Premature rupture of membranes at seven months. Baby died of prematurity.
20.	Baby died in two hours. Two previous babies born alive but died in less than eight hours. Patient received exceptional prenatal care. No cause found.
21.	Premature rupture of membranes. Intrapartum infection. Baby stillborn.
22.	Fetal heart heard on admission. Sounds disappeared after a few hours' labor. Stillborn. No cause found.
23.	Fetal heart heard on admission. Sounds disappeared after a few hours' labor. Stillborn. No cause found.
24.	Eclampsia at seven months. Cesarean section. Baby, two pounds, eleven ounces. Died of prematurity.

FETAL AND NEONATAL MORTALITY

The babies included in this study weighed, with a few exceptions, 1,500 or more grams. Neonatal deaths include all those born alive, but expiring within ten days.

Fetal Mortality.—To the one thousand mothers in this group, 1,003 babies were born. All of the twins survived, and so far as this study is concerned, can be counted as single pregnancies. Of these, thirty-three babies were either still-born or lived for less than ten days, except one monster who lived for five weeks, but is counted in this series nevertheless, a fetal and neonatal mortality rate of 3.3 per cent. I have divided these thirty-three babies into two groups: The first containing those babies whose deaths were, I think, entirely beyond our control, and in the second those cases in which I feel that, had our judgment been keen enough, some or all might have been saved. The first group contains twenty-four babies.

This group gives us an inevitable fetal and neonatal mortality of 2.4 per cent.

This leaves us a second group of nine babies, or less than one in each one hundred deliveries that might have been saved:

TABLE 6.—*Avoidable Fetal and Neonatal Mortality*

1. Placenta previa. Bag induction. Should have had cesarean section.
2. Placenta previa. Bag induction. Should have had cesarean section.
3. Great difficulty in delivering shoulders—large baby. Should have had cesarean section.
4. Version and extraction after attempted forceps. Should have had cesarean section.
5. Acute appendicitis at seven and one-half months. Diagnosis not made previous to operation. Cesarean section followed by exploration and appendectomy. Exploration and appendectomy should have been done, and the pregnancy allowed to continue.
6. Cesarean section after extensive repair. Patient went into labor at eight months. Baby weighed four pounds thirteen ounces. Died within twenty-four hours. No cause found. In the next pregnancy, labor began again at eight months. Was successfully delayed until term by liberal use of morphin sulphate and a living seven-pound child obtained.
7. Cesarean section for sterilization ten days prior to term. Baby weighed six pounds and thirteen ounces, but died within thirty-six hours. Autopsy showed only slight atelectasis. Cesarean section should have been postponed.
8. Induction of labor by rupture of membranes. Multipara at term. Easy spontaneous delivery. Baby weighed six pounds thirteen ounces, but died within twenty-four hours. Autopsy done. No cause for death found. Induction should not have been done.
9. Induction of labor by rupture of membranes. Multipara at term. Very easy low forceps delivery. Baby died in twelve hours of cerebral hemorrhage. This is the only proved case of cerebral hemorrhage in the series. Labor should not have been induced.

IN CONCLUSION

This combined fetal and neonatal mortality of thirty-three per one thousand deliveries is less than half of that generally reported. In other words, by this operative system of obstetrics, we have saved the lives of many babies. This is necessarily so from a study of the above tables which show that only two babies died from the actual trauma of delivery. The reason for this very low fetal and neonatal death rate from birth injuries is explained by our high incidence of cesarean section. Seriously injured babies are rare in this series for the same reason.

After carefully reviewing the records of these one thousand women considering the low maternal mortality, the large number who actually have living healthy uninjured babies, their own present health and future well-being, I have come to the conclusion that, in our hands at least, this largely operative means of conducting labor has yielded very gratifying results.

490 Post Street.

DISCUSSION

JOHN VRUWINK, M. D. (1136 West Sixth Street, Los Angeles).—This is an interesting review of one thousand labors conducted according to an operative conscience. The proof of any organized method of conducting labor depends upon the results obtained, as measured not only by living mothers and babies, but by well mothers and well babies. We must concede to Dallas and Stephenson that they have shown enviable end-results. We should be reminded, however, that Plass in a recent study of all labors in the State of Iowa, over a period of three years, found a positive increase in fetal and maternal mortality when labors were terminated by operative interference.

A short second stage, provided that it is not precipitous, is beneficial to both mother and child, and provided such descent and rotation is obtained according to sound physiological and basic principles. Dallas says the second stage averaged forty-five minutes, which is probably due not only to operative assistance, but to the fact that they avoided undue analgesia and narcosis during the first stage.

It might be conceded that the true low elective forceps operation should not be placed in the same category as indicated operative obstetrics. If one should do so, the very high incidence of operative interference is reduced to 22.7 per cent, of which 13.4 per cent is represented by cesarean section or an indicated operative interference from below of 9.3 per cent. The low fetal and maternal mortality, particularly, connotes the results which may be obtained, when good obstetrical judgment and management reduce the incidence of real operative interference, such as version and extraction, and high and even mid-forceps.

This study shows an incidence of cesarean section of 13.4 per cent. To most of us, it is out of proportion; yet in a review of fetal deaths, Dallas would even increase this by four more sections. Abdominal delivery should be a conservative method of interference, and measured in terms of decreased maternal injury as well as an increase in living children, and the low incidence of definite pathological labors, Dallas and Stephenson might be justified in such manner of termination. It is true, however, that all large series of cesarean operations show an unavoidable maternal mortality of 3 to 4 per cent. In general hands, even this mortality is increased, and definite indications should still be the rule for advising an operation which has so accurately been shown to carry a greater mortality and morbidity than delivery from below.

I am surprised to find that cervical dystochia was only once found as an indication for section.

We may all congratulate Dallas and Stephenson on the results shown in this study, but in the final analysis they are good, not because there was an incidence of 62 per cent of operative interference, but since there is evidence of an honest obstetrical conscience, trained in sound judgment, for the management of pregnancy and labor.

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FREDERIC M. LOOMIS, M.D. (350 Twenty-ninth Street, Oakland).—I think I can hear the low rumble of discontent when this interesting, honest and courageous paper is published, and Doctor Dallas' 13.4 per cent of cesareans and 83 per cent of forceps or other operative deliveries in primiparae are received with their full impact. The famous remark of a former state president that some day someone would "attain undying fame by rediscovering the birth tract" seems prophetic.

And yet, careful study of this paper is the best answer I have seen to the outcry against "meddlesome midwifery." Two or three years ago Peralta Hospital, in Oakland, was questioned by the American College of Surgeons for a 10 per cent cesarean incidence, and I had the pleasure of examining each history, with the inevitable conclusion that several of these mothers and numerous babies owed their lives to these sections; that none had died as a result of the operations; and that others owed their health to the fact that they had avoided the inevitable damage of taking a baby through a funnel. Why in the world do we measure pelves if we are not to use these measurements for the good of the patient? And why do we let a woman struggle for hours with the head on the perineum, when we know that under modern conditions, in well-trained hands, low forceps will quickly and safely relieve the pain of the mother and the pressure on the baby's head? It is not meddlesome midwifery to use the skill and judgment from thousands of preceding deliveries to further the safety of the woman that moment in our hands by any means that we have found we could use to her best interests.

I may add further cause for criticism in saying that I think the percentage of sterilization as a cause for cesarean—one case in a thousand deliveries—is far too low. I think that when a woman has had several children and there are physical, marital or economic reasons why she should not have more, or even if the only reason is the urgent and carefully considered desire of the patient and her husband that the burden of further pregnancies or the fear of pregnancy be lifted, then they have a perfect right to ask that medical skill be extended to cover that need, and that the tubes be ligated or the fundus removed. In most cases I think the latter to be the better procedure, especially in older patients.

On the whole, I am delighted with Doctor Dallas' paper, and urge its careful study by those who have modern hospital facilities, and the ability and courage to choose the right procedure and carry it through.

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Donald G. Tollefson, M.D. (511 South Bonnie Brae, Los Angeles).—The analysis that Doctor Dallas has brought to our section is most instructive. It is a detailed obstetrical audit. It should be done more frequently. The use of analgesia in the early part of the first stage of labor has been demanded by the people through the large number of lay articles appearing in popular magazines. A shorter labor may not necessarily decrease the infant mortality, nor will the use of analgesia always result in slow, tedious and retarded labors. The benefit of relief of pain to the patient is obvious.

An operative incidence of 62 per cent seems high, but the results apparently justify this increase in interference. The American College of Surgeons is placing special emphasis on the maternity departments of approved hospitals during the coming year. The commonwealth report of the city of New York, showing that 20 per cent of the maternal mortality followed cesarean section, has caused considerable comment. Scandron reports from the Jewish Hospital in New York an incidence of cesarean section of one to two hundred and fifty deliveries in the past ten years. We know that in private obstetrical practice this could not be duplicated. However, too many cesareans are being done by both obstetricians and general surgeons, and we must reduce the number by carefully considering the indications. Lower mortality will come if less operative interference is resorted to by specialist and non-specialist alike.

As we view these indications they all seem justified, and in only one patient was the operation performed for sterilization. Ordinarily, this would hardly be acceptable for an indication for the abdominal delivery.

It is interesting to note that three patients were operated on during pregnancy without mishap. At the General Hospital in Los Angeles, we have found that a mortality of almost 100 per cent resulted when an operation on the intestinal tract was performed and the uterus was opened at the same time. It has been prohibited for the past several years. The maternal and fetal mortality is exceedingly low, and the author is to be congratulated on the excellent results obtained.

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Doctor Dallas (Closing).—I want to thank Doctors Vruwink, Loomis, and Tollefson for their very frank discussions of my paper. I learned a great deal during the preparation of it. The method employed was a tedious one, but I think that it was the only way in which I could get a comprehensive picture of our obstetrical practice. It meant the actual careful study of each of the one thousand histories, and I think it would be most enlightening to every obstetrician to undertake such a study.

It is absolutely impossible to get a true conception of obstetrical results without a complete study of each case, including the pregnancy, labor, maternal, fetal and neonatal mortality; maternal and fetal injuries, and the subsequent health of the mother and child. Studies based only on birth and death certificates are absolutely worthless and misleading. Those based on maternal mortality alone, as was the one recently conducted by the New York Academy of Medicine are valuable but, being incomplete, cannot help us very much in our efforts to improve our obstetrical results. As far as our own work is concerned, it must be understood that it is done under almost ideal conditions, being carried on in well-equipped obstetrical departments of five or six general hospitals in San Francisco. These departments, with one exception, are all well staffed with nurses and internes, and practically every facility is available for such emergency procedures as intravenous fluids, blood transfusions and major surgery. It would be absolutely impossible to carry on such practice without these facilities, and I hope that no one not thoroughly trained in obstetrics and who does not have every modern obstetrical and surgical facility available, and who does not have thoroughly trained assistants and nurses, will attempt to carry out this type of obstetrics. It could only result in disaster.

Doctor Tollefson said in his discussion that too many cesarean sections are being done by obstetricians and general men alike. It is my firm conviction that, given well-trained men and excellent hospital facilities, far too few cesarean sections are being done at a terrific sacrifice of babies' lives and future health. I feel perfectly sure that if every competent obstetrician carried out a thorough study of his cases and gave due consideration to maternal, fetal and neonatal mortality and to the subsequent health of his mothers and babies, the incidence of cesarean sections in their hands would rise markedly.

Doctor Tollefson asks about our operations during pregnancy. The two myomectomies were done for the relief of pain due to torsion of the pedicle. The cholecystectomy and appendectomy were done by a colleague who did not know of the existing pregnancy. The appendectomy and cesarean section were done on one of those cases in which a diagnosis could not be made. The patient was extremely ill, and the cesarean section was done before exploration with the idea of saving the child. As it turned out, however, we would have been much smarter had we done the exploration and appendectomy first, and left the pregnancy alone. Since that time we have done two appendectomies for acute appendicitis during pregnancy, one at five and the other at seven months. The convalescence in each case was uneventful. We have just recently removed an ovarian cyst as large as a small watermelon during the fourth month of pregnancy, and the pregnancy has continued uneventfully. In 1931, I removed an interstitial fibroid as large as an ordinary cantaloupe from the fundus of the uterus of a woman who was four months pregnant; the pregnancy continued normally, and she had a precipitate labor at term in spite of the fact that she was an elderly primipara. In other words, we operate during pregnancy without hesitation if operation is indicated, and we have had no bad results.

STERILIZATION*

By F. O. Butler, M. D.
Eldridge

Discussion *by E. S. Gosney, M.D., Pasadena; Paul Popenoe, Sc.D., Pasadena; Glenn Myers, M.D., Compton.*

CONSIDERING that many of the countries of the world are thousands of years old, this country, when only four hundred and seven years old, was the first to consider definite methods of trying to control the ever-increasing number of defectives coming into the world. The first step was taken by Indiana in 1899 without any legal procedure. However, in 1907 they enacted the first sterilization law in the world, California being second with such a law, passed in 1909. The first operation was performed in the Stockton State Hospital the same year, the next institution being the Sonoma State Home in 1911, California taking the lead of any other state or country up to date, having sterilized over 50 per cent of all those done in the United States. There are now twenty-six other states with sterilization laws, namely: Alabama, Arizona, Connecticut, Delaware, Idaho, Indiana, Iowa, Kansas, Maine, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

STERILIZATION FIGURES FOR THE UNITED STATES

Figures up to January, 1933, showed there had been 16,066 cases sterilized in state institutions under state laws, 8,504 or 52 per cent of this number having been done here in our California institutions, which is an increase over other states of approximately 23 per cent, covering a three-year period.

CONSTITUTIONALITY OF THE LAW

In some of the states the law has been declared unconstitutional. In the vast majority, however, the sterilization law has been reëstablished on a firmer and better basis. No state has ever voluntarily abandoned sterilization as a policy by a repeal of its law, which, of course, is quite gratifying. The law has been upheld by the United States Supreme Court, even to being constitutionally compulsory.

STERILIZATION IN FOREIGN COUNTRIES

Foreign countries which have similar laws are: Canada with two provinces, Switzerland, Denmark, Germany, and Danzig, a free city of Europe. England is making a big effort to have such a law enacted through Parliament. Japan is working on a bill to go beyond voluntary sterilization in order to rid that country of unsound hereditary qualities. China, so far as I know, has not taken any steps toward controlling their ever-increasing population, which is over four hundred million, the largest of any country in the world. Thousands die each year of starvation, which undoubtedly is far worse than preventing so many coming into the world to die off like rats. India, the second largest country, has taken steps along eugenical lines, having established a number of birth-control clinics at their chief hospital centers, these clinics being patterned after ours here in the United States. They are also considering seriously the enactment of sterilization laws. Should England pass their law, it probably will aid India materially in bringing about similar legislation. Many other foreign countries, including some of the smaller and more remote countries, are giving the question of sterilization considerable thought and consideration.

INFLUENCE OF PRESENT-DAY ECONOMIC BURDENS

The economic situation alone in the past five years has caused many to think more than ever that the burden of caring for those who cannot ordinarily care for themselves is ever increasing, and every effort should be made to lighten this burden. While we do not advocate sterilization as a panacea, yet we believe that, if practiced in all states and countries on an extensive basis, sooner or later, with the aid of educating the public along eugenic lines, mental hygiene, properly regulated birth-control measures, universal marriage laws requiring special health certificates and mental examinations, etc., as indicated, before marriage licenses will be issued, will enable us to see the results in many ways.

PREVENTIVE MEDICINE SHOULD CONSIDER THE PROBLEM OF HEREDITY

Preventive medicine has taken wonderful strides in the past few years, which has resulted in far fewer physical and mental handicaps. If we will only exert ourselves similarly along medical lines with the hereditary class, which most of the authorities believe far exceeds the secondary group as much as 75 per cent, I am convinced that it will in time not be necessary for us to be increasing the size of our institutions according to the increase in population, as we have in the past twenty-five to fifty years. Therefore, instead of such heavy taxes as now obtain for supporting institutions caring for the defective, insane, delinquent, and criminal, they will gradually be reduced. This money can well go for the betterment of the normal individual, who certainly has not had a fair chance, especially during the last five or six years.

EXPENSE OF OVERCROWDED INSTITUTIONS IN CALIFORNIA

Many schools and colleges have had to close their doors in the various states and countries, but I have yet to hear of any institution caring for those who have to be cared for in tax-supported institutions being closed. Practically all such institutions are, more than ever in the history of the country, overcrowded. Our state institutions here in California average almost 30 per

*From the Sonoma State Home, Eldridge, California.

Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

cent in excess of normal capacity, with no appreciable relief in sight for several years unless the revenue is materially increased. Had we not sterilized over ten thousand cases in this state up to this time, I am definitely of the opinion that the problem of overcrowding would be much more serious.

STERILIZATION OPERATION NOT COMPLICATED

In this modern age of surgery the operation of sterilization is so simple that we have but very little objection to the operation on the part of relatives—in fact, we have many requests for the operation before we have an opportunity to recommend the same.

On the males we do a simple vasectomy with a local anesthesia, and generally they are carrying on their usual occupation within two days' time.

In the female, of course, it requires a laparotomy. We resect one-half to one inch of the fallopian tube into the uterine cornu, ligate both the cut ends of the tube, suture the uterine muscles over the uterine end and suture the serous coat over this, making a triple barrier which ordinarily makes it impossible for the ovum and spermatozoa to get together. The patient is generally out of the hospital by the fourteenth day, and pursuing her usual duties at the end of the third week; unless there has been some pathologic condition present, which, of course, is always attended to at the same time, when the recovery is the same as in any ordinary pathologic condition.

POSTOPERATIVE PREGNANCIES

Pregnancies following the operation in our series of 2,524 cases comprise but one patient (colored), who had one child. A non-sterilized wife of one of our paroled male (colored) sterilized by vasectomy gave birth to a child, but from a subsequent social history we were convinced that this woman had a good chance to become pregnant by a man other than her husband. However, we took no chances, and did a second vasectomy on him. Likewise a second operation on the female. These cases were both paroled again, following their second operations, and no further pregnancies reported since, which is approximately three years ago. Our records show that these two individuals had their usual surgical technique and we were unable to definitely account for these results.

MARRIAGES SUBSEQUENT TO OPERATION

The operation in either sex, so far as our observation has been in 2,479 cases in the past twenty-five years, has not interfered in any way with their sex life other than the prevention of procreation. We now have over three hundred patients married, all of whom are leading normal sex life. The vast majority are happy that they cannot bear children, for persons of the type who know enough to marry can also appreciate their incapability of trying to raise a family. Some, however, do take some of their children they had before the operation back into their own homes, and care for them under supervision. The average defective individual who is sterilized is really incapable of having the responsibility of rearing children. Of this I am more convinced as time goes on. Regardless of whether their condition can be traced to hereditary or secondary causes, they should not be given an opportunity to have children on account of their inability mentally, financially and otherwise to properly care for them. One of my saddest experiences is seeing a normal child come to the Institution to see its defective mother. Therefore, I firmly believe that unless a child can be born of normal parents it ought not to be born at all.

VENEREAL DISEASES AND PROMISCUITY

Our observation of venereal diseases and promiscuity among our patients, up to date, bears out a survey made a few years ago of our institutions under the direction of E. S. Gosney, the director and founder of the Human Betterment Foundation of Pasadena, that sterilization does not increase either of them; in fact, we have far less such conditions following sterilization than we had before the operation.

Pathologically we have been unable to ascertain anything definite in either sex either during life or at autopsy. We have held quite a number of autopsies on sterilized cases, as we hold autopsies on approximately 75 per cent of all who die here, which averages about eight per month.

MORTALITY IN STERILIZED PERSONS

The mortality in our 2,479 cases to date is but three, none of which could be charged to the operation. One was a postoperative pneumonia, one had a criminal abortion about four days prior to the operation (having already a uterine infection which the surgeon did not realize until the operation was under way), and the third was one of low mentality, who tore off the surgical dressings and infected the abdominal wound with her own hands and so developed a general septicemia, all of these cases being early in our work, and we have had no fatalities since.

MARITAL HAPPINESS

The marriages of our patients fortunately work out approximately 100 per cent more successful than do the marriages of normal individuals, this success being due chiefly to our careful investigation of the mate, supervision by trained social workers for approximately two years after marriage, so preventing their struggle to care for a family of children, as obtains with the majority of those who have not been sterilized. The family in this latter class averages four or five children, as compared to approximately two in normal individuals.

INFLUENCE ON PAROLE AND DISCHARGE

Sterilization permits parole and discharge earlier from our institutions for those who can adjust themselves in normal society. This with the aid of specially trained psychiatric social workers and others whom we can get interested in the welfare of the patients.

In the Sonoma State Home we have as many as three generations in one family and many, of course, of two generations, which bears out the definite hereditary trend.

PROPORTION OF DEFECTIVES IN THE UNITED STATES

The White House Conference on Child Health and Protection estimated that about five per cent of the total population of the United States fall in the defective and mental classes. Considering that the institutions caring for this group have more beds than all the general hospitals in the country and that all are overcrowded to the limit, it is quite obvious that it is humanly impossible to segregate this enormous number. Therefore, it is quite imperative that we take definite steps along preventive lines. One suggestion other than has been mentioned is that of a workable sterilization law permitting sterilization of proper individuals without being committed to a state institution; this privilege to be granted to private surgeons, and private and county hospitals with the legal right and protection to perform such operations, the patients for operation to include the mentally deficient, insane, epileptics, defective delinquents and criminals who fall into the defective class.

IN CONCLUSION

In closing, we must be reminded that mental deficiency is one of the basic causes underlying many social problems. Most all social evils, such as crime, pauperism, sex delinquencies, unemployment, and the like, have some roots in feeblemindedness; so that in this day and age we must provide suitable care and prevention for the feebleminded, not only for their own sake, but also to protect the very foundation of society.

Sonoma State Home.

DISCUSSION

E. S. Gosney, M.D. (Human Betterment Foundation, 321 Pacific Southwest Building, Pasadena).—Civilization today faces the most serious problem of history, in what Doctor Butler characterizes as "the ever-increasing number of defectives coming into the world." At the same time, the federal census of 1930 reveals that California has the lowest birth rate in the United States. The number of children born annually to the white population of this State falls short by 30 per cent of replacing those who die. This decline is, of course, masked to general observation, by the continual immigration of new families from other states. But so far as the State's own birth rate is concerned, the only parts of the population that are not dying out are some of the foreign-born groups, such as the Mexican, and our great body of defectives and dependents.

In these circumstances, it is a matter of racial life and death. If intelligence and good citizenship are to survive, defectives must not increase. Segregation can be applied only to a small number. The one measure that will go farthest to check the increase of the most undesirable part of the population is that described by Doctor Butler—a surgical operation which sterilizes the patient without unsexing.

It is a little more than twenty-five years since California adopted its first sterilization law. For nearly nine years the Human Betterment Foundation has been studying the results of this law, and has made the facts public in a score of technical papers and a popular book. We have had the heartiest coöperation from Doctor Butler and his fellow superintendents, and from the State Department of Institutions.

At present we are making a complete second survey of sterilization in this State, in collaboration with the State Bureau of Juvenile Research. This will bring the subject up to date. The great body of evidence which we have collected amply confirms the conclusions that Doctor Butler has stated in his paper: the California law has been administered conservatively, sympathetically, and intelligently. The best friends of the measure are, on the whole, the patients who have been sterilized and their families. They, better than anyone else, know what this protection has meant to them.

The ten thousand sterilizations performed to date in our State institutions represent a good start, but they are an infinitesimal part of the known patients with serious mental diseases and mental deficiency. Why is not sterilization used more widely?

The only serious obstacle is ignorance on the part of the public as to what sterilization is and what it is not. Public education, therefore, is the next necessary step. The medical profession is the logical medium for this education. No medical man in the State can speak on this point with more authority than Doctor Butler, and his contribution is to be welcomed most heartily. But I hope that it will be only the beginning of a widespread effort to inform the public as to the legitimate use of sterilization so that this humanitarian measure can be made available to many homes that need it urgently, and would, without doubt, welcome it eagerly.

Paul Popenoe, Sc.D. (321 Pacific Southwest Building, Pasadena).—The problem of eugenic sterilization in private practice, to which Doctor Butler refers, is one that seems to me particularly worthy of further study. A survey of 426 sterilizations in private gynecological practice, made by a committee of the Los Angeles County Obstetrical Society, with Dr. John Vruwink as chairman, showed that 90 per cent were therapeutic, not more than one in every ten being eugenic in purpose. But nearly all of the sterilizations of men are either eugenic, or merely performed for the convenience of the patient.

The number of such sterilizations is increasing, though there are, of course, no statistics available. But there are several genito-urinary surgeons in Los Angeles who have performed several hundred vasectomies each in the last few years.

Contrary to what is often stated, it does not appear that these operations are illegal. There is no State law that touches on the subject in any way. From a eugenic point of view, it would be desirable to permit sterilization for eugenic reasons, only when the facts were either approved or at least registered, before some central authority; but since a law to that effect could not be enforced, it is hardly worth while to consider it.

While the operation may be abused, it has a legitimate and important place in preventive medicine, and should be used much more widely. Many low-grade families are producing physically or mentally defective children for the taxpayers to support, because they do not know how to prevent having children, or because they are too indifferent, careless, or alcoholic, to prevent conception. Some of them profit financially by producing such children, since they are thereby entitled to a larger allowance from the county charities. But in many instances they will welcome sterilization, and vasectomy of the husband is an inexpensive office operation, which will usually cause him to lose little or no work, and which would be of great value to the individual, to society, and to posterity. As Doctor Butler says, this phase of preventive medicine deserves more consideration than it has had.

Glenn Myers, M.D. (Compton Sanitarium, Compton).—Persons of very low-grade intelligence are little trainable, and constitute principally a custodial problem. If home conditions are adequate, they generally may be cared for at home. Otherwise they must be cared for in institutions. Such patients have such close supervision that, for the most part, they are not dangerous to the public.

Persons of higher grade intelligence defect are better trainable. The extent of trainability depends upon (*a*) the degree of intelligence defect, and (*b*) the stability of personality reactions. The lower the degree of intelligence the less is the individual trainable. An individual with a moderate degree of intelligence defect may be untrainable because of personality traits that interfere with trainability. With due regard for the importance of decreased control of natural impulses that results through even moderate intelligence defect, a careful study discloses that unstable behavior patterns of persons with the higher grades of intelligence defect generally depend upon the environmental influences that the persons have experienced since they came into the world. The term "environmental" is here used in its widest sense. Those persons of moderate degree of intelligence defect, whose environmental influences have all been good and consistent with the degree of their intelligence defect, are generally good citizens within the limitations of their adaptability as determined by the limitations of their intelligence.

The procedure of sterilization of persons with intelligence defect is, in my opinion, an entirely proper one. It should, nevertheless, be effected only after a careful study of the particular patient. Many neuropsychiatric conditions that formerly were believed to have been inherited, with greater knowledge have proved to be due to environmental causation. Intelligence defect continues to be the outstanding neuropsychiatric condition that is regarded to have been inherited. There has been some modification even of this viewpoint, as well as modification of the belief that the degree of intelligence defect is absolute from birth onward through the individual's life. "Intelligence" has been found to be complex when broken down into its component parts, and is not the simple organically determined state that it was formerly thought to be.

There are rather definite organic laws for the transmission of intelligence defect, and those persons with a considerable degree of intelligence defect should not be permitted to have children. They and their defective children are not able to take their place properly in the constructive program of our world. Sterilization of those persons as a safety-first procedure should be practiced whether the patients are cared for in their homes or in institutions. There is in this connection a definite responsibility to the world to prevent the multiplication of such defective persons, who are a liability to the world from many social and economic aspects.

While the persons with marked intelligence defect have less opportunity to bring children into the world and may, if their defect is sufficiently marked, be sterile without the necessity of artificially making them so, those persons with a higher degree of intelligence defect comprise a more serious problem. They generally have much more opportunity to bring defective children into the world. They are easily led into sexual implications. They are generally prolific and fail to use good judgment about the number of children for whom they can be responsible, and for the effects upon the world of their having children. Sterilization serves great advantage to our civilization in weeding out such unfit members thereof.

All circumstances in connection with each individual patient should be carefully determined and weighed before coming to conclusions about sterilization; but the practice of the procedure should be waived only when the circumstances are preponderatingly in favor of bringing good substantial citizens into this world which we try to improve.

THE LURE OF MEDICAL HISTORY*

MEDICAL LIBRARIES†

By Mildred S. Farrow
San Diego

II‡

EARLY EDITIONS OF MEDICAL TEXTBOOKS

HAVING considered, to some extent, the establishment of medical libraries, I will briefly review some of the early American editions of medical textbooks. Dr. John R. Cox, a professor at the University of Pennsylvania, published in 1806 the American Dispensatory. Dr. Caspar Wistar was the author of a system of anatomy which was very popular in his day. Dr. Nathaniel Chapman wrote a book on materia medica and therapeutics, and Dr. John Eberle on the practice of medicine. Dr. Robley Dungleson was the author of a medical dictionary which was the standard for many years. Dr. John C. Dalton, the first to introduce animal experimentation into the medical schools, became prominent as the author of a textbook on physiology which was used in many colleges. Dr. Austin Flint prepared an exceedingly popular textbook on the practice of medicine. Dr. Oliver Wendell Holmes, the genial author of the "Autocrat of the Breakfast Table," and professor of anatomy for a long time at Harvard Medical College, rendered a great service to the medical profession by calling attention to the contagiousness of puerperal fever—an honor which he shared with Professor Semmelweiss of Vienna. However, aseptic midwifery was advocated as early as 1773, when Dr. Charles White, a Manchester surgeon, made his plea for surgical cleanliness in obstetrics. Dr. William Dewees was the author of a textbook on the diseases of children which reached a tenth edition, while his "Midwifery" attained a twelfth printing.

MEDICAL JOURNALS OF AMERICA REFLECT THE DEVELOPMENT OF AMERICAN MEDICINE

Through the study of these old medical journals and textbooks, we are able to acquire an insight into the history of American medicine.

The eighteenth century practitioner had to be a very keen observer, as those were the days before the stethoscope, the clinical thermometer, the ophthalmoscope or laryngoscope, and the microscope had come into use for clinical purposes; so that the practice of medicine was, to a large extent, governed along empirical lines.

It was only when scientific medicine was being developed that we began to learn the etiology

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

† From the library of the San Diego County Medical Society.

Read before the Altrusa Club of San Diego, September 12, 1934.

‡ Part I of this paper was printed in the December issue of California and Western Medicine, page 401.

of the various diseases. The earliest vaccination against smallpox in the United States was performed by Doctor Waterhouse in 1800. Malarial fever was supposed to be due to foul air until 1880, when Laveran found parasites in the blood of malarial patients, and the etiology of yellow fever remained in doubt until 1900-1901. Tuberculosis existed for thousands of years and the clinical symptoms had been described quite accurately by Hippocrates, who thought that it was caused by the secretions of the head flowing into the bronchi; and it was not until Koch, in 1882, isolated the tubercle bacillus, that the true etiology was discovered.

During the past fifty years, medical science has undergone a greater growth than that which has taken place during the twenty-three centuries since Hippocrates. Until a comparatively few years ago, there was no science of bacteriology, no explanation of the origin of disease, rational treatment, aseptic surgery, the rôle of insects, x-ray or radium, and no serological diagnosis, especially of value in the diagnosis of syphilis or immunology.

We accept these advances in medical science with very little thought or appreciation of the laborious work of the investigator.

Textbooks in those days were very expensive, and students often passed their notebooks down to their successors. We of this age often fail to realize the great value of medical books to the profession and to the public.

THE MEDICAL LIBRARY'S PLACE IN THE DEVELOPMENT OF THE COMMUNITY

A medical library is an essential part of the educational feature of the community. A good medical library can help to elevate the standard of the medical profession, to improve medical practice and to enrich the teaching of medical students and nurses.

Research and discovery all help to contribute toward the health and hygiene of the community as a whole. The physician must keep up with the changing methods of diagnosis and treatment. One cannot purchase all the new books, or subscribe to all of the medical periodicals which contain the latest facts and opinions upon the different branches of medicine. In reality, the medical library is a postgraduate school for the physician. In its periodicals he finds the latest medical knowledge which he is able to use for the greatest benefit to himself and his patient.

In the laboratory, the research worker must know what has been done in the past, and for that purpose a good medical library is necessary not only to the physician but also to the laboratory investigator or biologist. The medical student must be encouraged to form habits of research, to examine original sources and to make investigations for himself. The progressive physician depends, to a large extent, upon medical journals, especially those specializing. Here he obtains the latest treatment of disease and is able, in the well-equipped library, to have access to a large number of medical periodicals published in many languages. When a new discovery is made, it is not long before the entire medical world learns of it.

If a medical man tried to supply his private library with the many medical journals published, he would find that it not only was prohibitive in cost, but in the space necessary to house such a collection.

In the medical profession there has been considerable discussion as to the relative value of medical journals and medical books. Journals often contain much that is only the experience of the author, and it is necessary to separate the wheat from the chaff. Textbooks, on the other hand, are the result of more mature judgment and, as a rule, only that treatment which has the approval of the profession is recommended. However, it frequently occurs that by the time a textbook is published it is behind the times—so rapid is the progress of the medical sciences.

THE NEED OF MEDICAL LIBRARIES

It is my opinion that a greater responsibility than ever rests upon the medical profession in giving sound advice upon medical subjects, especially those of preventive medicine and hygiene. This also is necessary in order to preclude, as far as possible, unwise laws from being placed on our statute books, as we are still, in some regards, living in the Middle Ages.

It is also very necessary to turn to medical literature while studying disease in order to learn of the experiences of the past. Many diseases present different variations over a course of years. There is frequently a marked variation in the severity and course of the symptoms.

There is often, too, a tendency toward an intellectual rut if there is nothing to spur one on. There are so many new discoveries, especially in endocrinology, for example, that if one does not consult the medical journals frequently, he will fall hopelessly behind, as what was accepted yesterday may be obsolete on the morrow.

ADMINISTRATION OF A MEDICAL LIBRARY

A medical library is of little value unless it is properly classified and catalogued, and in order to accomplish this someone must be in charge who is trained in medical literature. Another advantage to the busy physician is that of being able to obtain the desired information quickly—which leaves him more time for the study of his patient. A review of medical literature also helps one to avoid the mistakes of the past and the duplication of effort.

Doctor Jacobi has called attention to the fact that many of our modern discoveries were suggested years ago, and that if proper attention had been paid to the writings at the time, it would not have been necessary for suffering humanity to be compelled to wait so long for relief.

The medical librarian should also keep abreast of the times if he or she is to be of the greatest possible service, and should have a comprehensive

knowledge of medical literature, the new treatments being advocated and, through the public health reports, should know of the prevailing diseases and when these diseases are epidemic in character. Such a librarian should be able to lay hand upon the latest information on the subject and so anticipate the needs of the physician.

Very few of the general public realize that scientific medicine is keeping pace with the other branches of science. Medical advances are often unnoticed for some time, except by members of the medical profession, due to the lack of publicity, as was the case with the airplane, the radio and various other discoveries now in the public eye.

FACTORS WHICH MAKE FOR THE SUCCESS OF A MEDICAL LIBRARY

The success of a medical library is dependent upon the following factors: proper housing, trained personnel, and sufficient funds to keep the collection up to date. It is not the quantity but the quality that counts in medical literature, and I know of no greater opportunity for the philanthropist in the alleviation of human suffering than to provide proper endowment of a local medical library. This would help the physician to give to both the rich and the poor the very best treatment known to medical science.

IN CONCLUSION

To me, a medical library is filled with interest in that it contains the records of the marvelous achievements in the field of medicine. In the literature housed in each medical library are the records of the unselfish devotion of thousands of physicians and nurses in their efforts to relieve suffering.

It is regrettable that, to the memory of great military leaders like Napoleon and others, the world erects monuments, while many of the greatest benefactors of the human race go unnoticed and unheralded. Their names, however, live on in the pages of medical history enshrined in the medical libraries throughout the world.

1410 Medico-Dental Building.

Substitute for Cocain and Procain in Rhinolaryngology. Gatewood states that the 2.5 per cent solution of nupercain has proved to be a most satisfactory agent for causing topical anesthesia prior to such operations as submucous resection, ethmoidectomy, intranasal antrotomy and turbinectomy. The 2.5 per cent solution of nupercain produces prompt, effective and prolonged anesthesia without signs of local irritation or of systemic intoxication. When used in 1:1,000 solution with epinephrin, nupercain has been found fully as effective as a 1 per cent solution of procain hydrochlorid for infiltration anesthesia prior to tonsillectomy. Nupercain has the advantage over procain for infiltration in that the duration of the anesthesia produced by the former far exceeds that following injection of the latter; as a consequence, the tendency for postoperative bleeding is less when nupercain is used as the anesthetic agent. In the routine operative work in the rhinolaryngologic clinic at the Polyclinic Hospital, nupercain has been employed in 87 submucous resections, 36 ethmoidectomies, 29 intranasal antrotomies, 41 turbinectomies, and 212 tonsillectomies. The author describes his method of procedure in each of these operations.—*Laryngoscope.*

CLINICAL NOTES AND CASE REPORTS

RAT-BITE FEVER

REPORT OF CASE

By George E. Koerber, M. D.
San Leandro

RAT-BITE fever is a disease occasionally seen in the United States, some fourscore cases having been reported in this country up to 1931. Reports of several recent cases have also appeared in the journals.

It is not the purpose of this communication to describe the disease academically, but simply to present a case history which illustrates its typical course.

REPORT OF CASE

T. T., a boy of twelve, was admitted to the Alameda County Hospital on March 27, 1934, with the complaint of recurring bouts of fever. Two months previously he had been bitten by a rat in one of the large public markets in Oakland. He had thought the rat was a guinea-pig and tried to catch it. The boy said the rat had acted sick, and this is probably so, or he could never have gotten so close to it. After being bitten, he went to a doctor, who applied iodin and a small dressing.

The wound healed rapidly, and for three weeks nothing further was thought of it. Then the site of the injury, the right palm near the base of the thumb, became inflamed and swollen. He again went to a doctor, who lanced the swelling but obtained no pus. At this time the doctor discovered axillary adenopathy. The hand healed rapidly after incision.

Two weeks after this, the attacks of fever began. They occurred regularly on Monday and Tuesday of each week, lasting about forty-eight hours, and at regular seven-day intervals. The boy entered the hospital on a Tuesday, toward the close of his third recurrence.

Each attack was characterized by extreme weakness, backache, an ache in the right arm, moderate chills, a high fever, and very severe night sweats. Between the bouts the boy felt fairly well.

Examination at entry revealed: (1) A temperature of 105.8 degrees Fahrenheit. (2) Tenderness in the left upper quadrant, with a barely palpable spleen. (3) Generalized lymphadenopathy, enlarged glands being felt in the neck, both axillae, and the inguinal regions, the glands in the right axilla being largest and most tender. (4) No skin lesions were found, and they were denied in the history.

A number of blood smears were taken at entry, while the fever was still at its height, and examined after staining with both Wright's and Giemsa's. These were negative. A lymph-node was aspirated the following day and the fluid examined, but no spirochetes found, either in darkfield or stained specimens.

The white blood count was 14,900, with 82 per cent neutrophils. Red count, 3,660,000; hemoglobin, 10.8 grams, or 64 per cent. Urinalysis was negative. Further laboratory work included: (1) Agglutination against organisms of undulant fever and tularemia, both negative. (2) Blood culture, which was negative.

After being in the hospital five days, the fourth bout of fever began. During this recurrence, one of the large axillary glands was removed surgically. Material from this gland was inoculated into two rats. Microscopic section of the gland itself showed only hyperplastic lymphatic structure. Blood obtained from the patient by venipuncture was inoculated into a guinea-pig after citration.

Sixteen days later one rat and the guinea-pig were autopsied, and in the blood of each were found spirochetes, fairly numerous in the rat blood, but scarce in that of the guinea-pig. These spirochetes agreed very closely in morphology with the descriptions of Leptospira morsis-muri given in various texts. The other rat was allowed to live six weeks, and no spirochetes were found in its blood at autopsy.

Three intravenous injections of neoarsphenamin, three-tenths gram each, were given at four-day intervals. We started this before the laboratory had confirmed our diagnosis, because we hesitated to subject the patient to another such attack of fever. Fortunately, however, confirmation was soon forthcoming.

The patient had no more attacks of fever, and was soon discharged as recovered. In a recent communication from his mother, I am told that he had one or two attacks of malaise and light fever about a month after leaving the hospital, and also had a red rash in the right axilla which disappeared spontaneously. Whether these bore any relationship to his previous illness I cannot state. Otherwise he has been well for six months.

SUMMARY

1. A proved case of rat-bite fever occurring in Oakland is presented.

2. Inoculation of laboratory animals is the only method of laboratory diagnosis offering any certainty.

Fairmont Hospital.

AN UNUSUAL BRAIN INJURY

By Alfred H. Tickell, M. D.
Nevada City

HEREWITH find a report on an unusual case of brain injury, with recovery.

REPORT OF CASE

On July 25, 1934, at 1 p. m., Mrs. A., age about 30, attempted suicide at her home in Truckee, California, by shooting herself through the head with a 32-caliber automatic revolver.

Mrs. A. was received at the Nevada County Hospital, Nevada City, California, at 6:15 p. m. the same day, where examination showed powder-burned point of entrance through the right temporal region, and the point of exit on the left side at a slightly higher level; the bullet passing, without doubt, anterior to the motor zone.

The woman was semi-conscious, suffering from hemorrhage and shock. There was considerable bleeding, and the eyes greatly swollen and ecchymosed due to laceration of cerebral vessels. Brain substance was coming from both bullet holes.

Tetanus antitoxin was given, and the wounds carefully cleansed, and small, loose pieces of bone removed at point of exit.

A few sutures were temporarily placed, with the idea of partly checking the hemorrhage, with aseptic packs and bandages. The sutures were removed twelve hours later, and the wound dressed every eight hours until cessation of bleeding.

During this period there was a constant loss of brain substance, totaling about half an ounce by volume. On July 28, Dr. Howard C. Naffziger of San Francisco was called in consultation, and advised continuance of treatment and close observation of any following symptoms before anything more radical was undertaken; finding no evidence of intracranial pressure. The patient, according to his report, was still somewhat stuporous, but the response suggested a mild degree of aphasia. He felt that the ecchymosis about the orbits indicated a probable fracture of the orbital plates. The wounds were clean, and it was felt that the patient had automatically freed herself of most of the devitalized brain tissue by extrusion of it through the wounds. There was no tendency, as a matter of fact, for the formation of a brain fungus at either wound.

For the first ten days the patient's temperature ranged from normal, in the morning, to 101 degrees Fahrenheit in the evening; and she was slightly irrational for the first four days.

Excretions were involuntary for the first ten days.

Medication was confined to an occasional hypodermic of morphin.

After this date the patient's symptoms were negative, except some headache and restlessness, since cleared up. Her reflexes and special senses were normal, and have remained so, with the openings in the skull closed. The points of penetration are shown in the accompanying photographs.

The patient returned to her home on August 25.

Office of County Physician.



Fig. 1.—Showing entrance site of bullet.



Fig. 2.—Showing exit site of bullet.

HERNIAS OF INFANCY

By Edwin F. Patton, M. D.
Los Angeles

WHILE the principles of treatment of hernias in infancy are no different from those applying to the same conditions later in life, in practical management certain special considerations must be observed.

The questions of spontaneous healing, elective age for operation, and nursing care at operation, require particularized answers.

Fundamental to the whole situation are two facts:

1. Whenever a congenital hernia exists, it means that a hernial sac is present.

2. Whenever a hernia cures itself, it does not mean that the sac has obliterated itself. It means that adhesions have formed across the neck of the sac, sufficient to withstand ordinary intra-abdominal pressure, and that the ring through which the hernia emerged has become smaller or more resistant, thus assisting in restraining the viscera from forcing their way through. At best it is a makeshift and an unreliable cure.

In dealing with hernias of infancy, most parents insist—and it is only fair—that the logical procedure be, first, to afford reasonable opportunity for spontaneous cure; then, if the desired result is not forthcoming, the quick, sure method of surgery must be applied.

The answer to the question as to what constitutes a reasonable period is: In inguinal hernias, three to five months; in umbilical hernias, twelve to fourteen months; and in either case till the child is in a good state of general health, with good muscle tone.

During such a period, the hernia must be kept reduced by means of some external appliance. Any appliance which holds the viscera in the abdominal cavity efficiently is acceptable. For the inguinal type, a simple figure-eight spica of yarn is as good as any, if the mother can keep it in place and sanitary. For the umbilical, a transverse adhesive strap two inches wide by eight inches long, applied over folds of skin turned in vertically from each side of the defect to form a splint, is satisfactory. This tape should be left on as long as it will stick, since changing is hard on the skin. If skin is abraded, reapplication may have to be angled to avoid the irritated areas as much as possible. Once tape has stuck firmly, it is not interfered with by bathing.

Most umbilical hernias will shrink to negligible proportions if supported faithfully.

If the umbilical hernia is conical with a wide opening, however, it tends to persist regardless of support.

After consistent maintenance of reduction for the designated period, if the infant is strong and well-muscled, the truss or tape is removed. Then, if recurrence takes place, possibility of spontaneous cure is negligible, and operation is the only logical resource.

When operation has been decided on for an inguinal hernia, the sooner it is done the better; best of all, before the babe begins to stand. Ligation of the sac is the chief essential. Suturing does not need to be as extensive as in adults. The less dressing applied, the better. A recommended type of after-care is *no* dressing; the diaper laid under the buttocks, not pinned; the bed clothing kept off the wound by a cradle; extra warmth by means of an electric-light globe or heating pad, if necessary; and, in case of boys, a urinal taped to the penis, if necessary to prevent sprinkling of the wound.

An umbilical hernia, which continues to protrude after the child is running around, should be repaired surgically. A very small skin incision may be made in the folds of the umbilicus itself. The sac is then exposed and its tip detached from the skin. It is then split down to the abdominal wall, where it is almost invariably adherent to the aponeurotic ring. The split flaps can be used to close and reënforce the opening by lapping over each other in whichever direction is easiest. Usually there is no other, or very little other fascial tissue present to pull together; but whatever is found may be used. Closure of the skin wound leaves very little perceptible scar. After-treatment consists merely in a strong tape corset, and dressings as infrequent as possible. Activity need not be greatly restricted. Complete restraint would be practically impossible anyway.

Supra-umbilical hernia is usually merely a pouting, without actual herniation, through a thin spot in the linea alba, and seldom requires attention.

3875 Wilshire Boulevard.

Spadra State Narcotic Hospital.—With state-wide economic conditions operating to reduce the number of patients admitted to the State Narcotic Hospital at Spadra, Dr. Thomas F. Joyce, superintendent, has found that the cloud has a decidedly silver-hued lining.

Only forty-five men are at the hospital now, compared with fifty-five last November, and incoming cases are being more carefully selected. Men whose narcotic drug addiction is so complicated with other diseases that eventual recovery is highly doubtful are being assigned to other institutions. . . .

Hospital records show that, so far, between 25 and 30 per cent of men treated at Spadra have won their battle against narcotics. This percentage, Doctor Joyce believes, should be increased materially with elimination of many hopelessly irreclaimable cases.

Enforced economy in county administrations—a county pays $25 a month for each patient from its area—is held partly responsible for this drop in hospital population. . . .

The great dream of Doctor Joyce and his staff, now as always, is establishment of a narcotic farm, where men might be sent after completing their hospital treatment, to stay for a period of years and to which they could be returned if they violated parole. At present, a paroled man necessarily is thrown largely upon his own will power when, released from the hospital, he goes back into ordinary life—almost invariably to find old companions waiting with perilous suggestions. Even the most careful follow-up system cannot prevent this. . . .

The Spadra hospital, located in the hills east of Los Angeles, represents an investment of about $250,000 in buildings and land. It is adequate to care for many more patients than those now receiving treatment. Vegetable gardens provide work for the men and food supplies.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

INTESTINAL OBSTRUCTION

I. SYMPTOMS

Charles T. Sturgeon, M.D. (1930 Wilshire Boulevard, Los Angeles).—The symptoms of intestinal obstruction are not always typical. They vary in character and intensity according to the type of the obstruction—whether it is of the simple mechanical type, partial or complete, of the strangulation type, or whether the lesion is in the large intestines.

The most constant symptoms are pain, vomiting and obstipation. Pain is the most striking and positive symptom. It is usually of sudden onset, colicky and intermittent in character; although, after twelve to twenty-four hours, it may be continuous. It varies greatly in intensity and location and, if strangulation has occurred, it is often agonizing and may even be severe enough to lead to the early collapse of the patient.

If the obstruction is in the small intestines, the pain is generally referred to the median line at or above the umbilicus or even to the epigastrium. But if the obstruction is in the large intestines, the pain is usually felt below the umbilicus and occurs in cramp-like paroxysms with longer intervals of freedom. The patient may be able to locate the point of obstruction with considerable accuracy, and, if the obstruction has existed for some time, the pain is often localized over the site of the obstruction, probably because of edema and infection. In patients with a laparotomy scar, the pain may be referred to the region of the scar. In the late stages, the pain diminishes with the exhaustion of the intestinal musculature and the cessation of peristalsis.

Vomiting is also a constant symptom and is associated with the paroxysms of pain, or follows soon after the attack. At its onset it is reflex in character, such as occurs in any acute abdominal lesion, and consists of retained food. Later, it is bile-stained fluid; and if the vomiting continues, it becomes the characteristic regurgitant vomitus of intestinal obstruction—a thin, light brown, opaque fluid with feculent odor.

The rapid development of regurgitant vomiting and toxemia points to a lesion in the small intestines. If the vomitus is persistently bile-stained duodenal contents, without becoming feculent in character, a high jejunal obstruction is suspected. If pain persists over a long period of time before vomiting occurs, and if abdominal distention becomes marked and the vomiting only occasional, the lesion is probably in the colon.

Obstipation is ordinarily present. In a certain number of cases not infrequently following the onset of the symptoms, one or two evacuations of the contents of the bowel below the obstruction may occur. Following this, failure to obtain even gas in spite of the use of enemata and associated with abdominal pain is very suggestive of acute intestinal obstruction.

In a certain number of cases of intestinal obstruction, on auscultation borborygmi can be heard. It is a fact that borborygmi is also present in other acute abdominal conditions; but if it is heard at the height of the intermittent crampy pain, it is typical of intestinal obstruction.

The general condition of the patient, in simple intestinal obstruction, is usually not disturbed until late, although the appearance of the patient indicates the presence of serious intra-abdominal pathology.

The pulse, temperature and respirations are not likely to be elevated early except in cases of strangulation obstruction.

Leucocytosis is of very little importance. A high leucocytosis during the onset of bowel obstruction is suggestive of interference with the circulation of the bowel.

During the first stages of simple obstruction there is very little if any abdominal tenderness. In the strangulation type, there is generally local tenderness and abdominal rigidity early in the disease.

Distention of the abdomen is frequently absent in the early stage, and may not be marked even in the late cases if the obstruction is high. In the cases with extreme abdominal distention, the obstruction is probably in the large intestines. If the distention is in the upper abdomen, or, if existing to a moderate degree it is associated with severe symptoms, a lesion of the small intestines is suspected. A localized or asymmetrical distention is indicative of strangulation of a coil of intestines or of a volvulus.

Visible peristalsis is rarely observed in the early cases, and is usually well developed in direct proportion to the length of time that the obstruction has been present. According to the reports of many clinics, this symptom occurs in approximately 22 per cent of cases. A palpable mass can be found in only a small number of cases and is suggestive of intussusception.

Changes in the chemistry of the blood, such as the diminishing of the chlorids, the elevation of the non-protein-nitrogen and increase in combining power of CO_2, occur consistently only in high obstructions, and then only after persistent vomiting of forty-eight hours or more.

The symptoms of spastic obstruction are the same as in mechanical obstruction, but usually the general condition of the patient is less grave.

In paralytic ileus the predominant symptoms are abdominal distention, complete obstipation,

continuous vomiting, absence of pain and absence of boryborygmi. As the case progresses, vomiting is continuous and abdominal distention increases. Dehydration occurs early. The pulse increases in rate, while the capillary circulation assumes a sluggish appearance. Seen in this stage we can only recognize a deeply toxic patient in whom death is imminent.

* * *

II. DIAGNOSIS

Edmund Butler, M.D. (490 Post Street, San Francisco).—*Outstanding Symptoms:*

1. Pain
2. Nausea
3. Vomiting
4. Constipation

Physical Examination:

1. Inspection
2. Auscultation
3. Percussion
4. Palpation
5. Rectal examination
6. Laboratory tests
7. X-ray
8. Spinal anesthesia

Mortality from bowel obstruction is in direct proportion to the difficulty of diagnosis. The mortality in a series of ninety-seven cases of bowel obstruction, thirty-four of which were strangulated hernias, was 8 per cent, while the mortality in the obstruction due to intra-abdominal conditions was between 30 and 50 per cent. There are many conditions that may cause bowel obstruction, so it is not wise to lose time in attempting to ascertain the exact location of the obstruction, or the exact cause of the obstruction, for delay is most dangerous. Five or six hours of indecision may spell the difference between recovery and death.

1. *Pain.*—Pain is the one most valuable diagnostic symptom. The character of the pain depends upon several factors:

a. The extent to which the lumen of the bowel is obstructed.

b. The extent to which the circulation of the bowel is disturbed.

c. Whether the obstructing agent is an acute inflammatory condition.

d. Whether the obstructing agent is free in the lumen of the bowel.

(*a*) If the obstructing agent gradually obliterates the lumen of the bowel, the intermittent cramps are not severe early, and some gas and liquid bowel contents may be expelled. But as the obstruction becomes complete, the cramps are more severe and more frequent. Both frequency and the severity of the pain decrease as the musculature tires, and toxemia becomes more marked. The "tiring of the bowel toxic stage" leads the patient and relatives, and even the medical attendant, to feel that improvement is taking place and delay is justifiable. A close check on the pulse, blood pressure, and blood chemistry will show that the patient's condition is not improving.

(*b*) If a loop of bowel is encarcerated, the pain is intermittent as long as the obstructing agent prevents the bowel contents from moving. As the circulation becomes disturbed, the interference with venous return results in an edema of the bowel wall, which in turn interferes further with venous return, until finally complete venous stasis takes place. Then all vessels are engorged, finally resulting in extravasations into all coats of the bowel and complete vascular arrest and gangrene. During these changes the pain at first is cramp-like, but between cramps a constant, dull pain is usually present. This pain becomes more intense as the retardation of the circulation increases, and finally this constant pain entirely supplants the cramp-like pains.

(*c*) If the obstructing agent is an acute inflammatory condition, the local pain often precedes the intermittent cramp-like pain.

(*d*) If the obstructing agent is a loose foreign body in the lumen of the bowel, such as a gall-stone, the intermittent contraction of the bowel may not be severe and the resultant pain may not be marked. But often there is sufficient obstruction to produce a very slow absorption so that a very low grade toxemia gradually develops, and in spite of the fact that gas and bowel contents may be passed, the toxemia may be sufficient to cause death before the gall-stone is passed. This type of obstruction is not easily diagnosed because of the periods of supposed well-being.

2. *Nausea.*—Nausea is usually present and precedes vomiting, unless there is bowel injury.

3. *Vomiting.*—Vomiting is always present at some stage. A patient may develop a severe toxemia in partial bowel obstruction without excessive vomiting.

4. *Constipation.*—Constipation may be absolute, but if the circulation is not disturbed or the bowel uninjured, the bowel contents and gas below the obstruction may be expelled, and still the obstruction may be complete.

Physical Examination:

The physical examination is very often misleading. Great reliance must be placed on a carefully taken history, and particularly on the development and progress of the symptom of pain.

1. *Inspection.* — Distention in one particular area may be visible. Sagging flanks may suggest the presence of fluid. Visible peristalsis is very seldom seen in acute obstruction except in a very emaciated patient. Visible peristalsis practically always indicates hypertrophy of the musculature of the bowel, and is present in chronic obstruction.

2. *Auscultation.* — Auscultation is very important. Dr. S. Stillman frequently stated that "the auscultation of the abdomen is just as valuable as auscultation of the chest." The surges of peristalsis may be heard in their incipiency, gradually increasing, and reaching a climax; and the accom-

panying look of distress on the patient's face is diagnostic. The splashing peristalsis is heard as dilatation of the bowel takes place.

3. *Percussion.*—Percussion is valuable in outlining masses, and engorged and distended loops of bowel. Very slight degree of abdominal tenderness is brought out by percussion.

4. *Palpation.*—Masses and regions of tenderness are located.

5. *Rectal Examination.*—A rectal examination must not be neglected. Masses and tenderness may be outlined or located.

6. *Laboratory Tests.*—The laboratory is not of much value in the early diagnosis. The blood chemistry is very valuable in checking the condition during the course of the disease.

7. *X-ray.*—A flat plate of the abdomen should always be taken if it does not necessitate great delay or much handling of the patient. The patient, having given a history causing you to suspect bowel obstruction, should not be given, as a rule, barium by mouth. In obstruction of the colon, opaque enemas often help locate the point of obstruction. The radiologist, unless he has had considerable experience and follows the patients to the operating room, should be very guarded in making any positive statements.

8. *Spinal Anesthesia.*—The diagnostic value of the spinal anesthesia is questionable. It has been noted in operating upon strangulated hernia under spinal anesthesia that in two patients the bowels moved before obstruction had been released; and had these been internal hernias I would have concluded that the obstructing agent had been released.

9. *Pulse and Temperature Are Not Changed Early.*—To summarize: Physical findings and laboratory findings in early obstruction may not be remarkable, but a carefully taken history, particularly bringing out the relation of pain to nausea and vomiting, and the character of the pain which has not been relieved by abdominal stoops, stomach washing, enemas, catheterization of the distended bladder, should not be considered lightly.

It has always been my policy, whenever I feel like delaying, to have consultation. The differential diagnosis is often difficult, but it is far better occasionally to explore for a condition that is not surgical than to treat expectantly a condition that very gradually grows definitely worse, and late intervention is followed by a very high mortality.

* * *

III. TREATMENT

John Homer Woolsey, M. D. (Woodland Clinic, Woodland).—This discussion pertains to a mechanical obstruction and not to "paralytic" or inhibition ileus. In the treatment of such, one's attention is drawn primarily to the symptoms formerly ascribed to "toxemia," but which we believe today to be due to several factors, as dehydration, demineralization, disturbance of gastro-intestinal secretion and absorption, disturbance in the bowel-wall function from distention, disturbance in the splanchnic circulation, and at times a peritonitis.

Six to eight liters of gastric, hepatic pancreatic and duodenal digestive juices are secreted daily, passed down into the ileum and right colon, and then reabsorbed. If this fluid is lost by vomiting or by failure of reabsorption, serious damage may occur. This loss leads to a depletion of important electrolytes (CL ions especially) to dehydration, demineralization; and, secondarily, to change in the viscosity of the blood and, at times, to an alkalosis.

The distention leads to an interference in the circulation, in circulatory absorption, in motility; because of the deranged function, at times there is a permeability to microörganisms that would never otherwise occur.

Therefore, treatment should be directed primarily to a restoration of the fluid and mineral balance and, secondarily, to correction of the obstruction.

Preoperative Phase.—Fluids to the degree of tolerance may be stated to be a general rule. These will have to be given subcutaneously or intravenously. Rectal instillation is of little account, and is mentioned only to be discarded. For the loss of minerals and the CL ions, it is best to give to the adult, if possible, 1,500 cubic centimeters of normal sodium chlorid, or Ringer's solution or Hartman's solution in the thighs (inner side subcutaneously preferred, or outer side intramuscularly). This will be absorbed as needed. It is recommended that there be given at the same time 700 to 1,000 cubic centimeters of 5 or 10 per cent glucose intravenously, at a rate of not faster than 150 cubic centimeters per ten minutes.

During this period a Levine gastric catheter should be passed, and the upper gastro-intestinal tract drained of all residual content, washed clear, and 100 to 250 cubic centimeters of normal sodium chlorid solution, or even 3 per cent sodium chlorid left in the stomach.

As a rule, one and one-half to two hours after the fluids are given and the gastric lavage effected, the patient will ordinarily be in the best condition for surgical release of the obstruction.

Operative Phase.—The type of anesthesia to be employed is of considerable importance. If the patient's blood pressure and vascular system does not contraindicate it, spinal anesthesia, so given as to reach only to approximately the sixth dorsal level, is the type recommended. Intravenous saline administration during the surgery will often prevent the greatest drawback—the fall in blood pressure. Otherwise, a gas anesthesia may be employed, with only sufficient ether to secure necessary relaxation.

Choice of procedure is difficult to outline. There are indications, such as with very ill or elderly persons, or those with a long-standing obstruction, where only an enterostomy of the distended loop should be performed under local anesthesia. Ordinarily, however, a sufficient incision and exploration should be made to find the cause, and release of it with as little manipulation of the bowel as pos-

sible. It is frequently necessary to exteriorize the damaged bowel somewhat, and when done, careful protection of the bowel to loss of heat or moisture should be made. We would rather see a certain amount of exteriorization than the haphazard mauling and pawing of intestines in an attempt to locate the site of the obstruction. If the collapsed and quite normal gut is located and followed upward to the obstruction, all unnecessary handling of distended and injured bowel is avoided.

Decompression of the distended small bowel by the method as outlined by Holden of Portland, Oregon (see CALIFORNIA AND WESTERN MEDICINE, Vol. 31, No. 6, pp. 403-405), if it can be done expeditiously and properly, has been proved justifiable by the observed comfort and immediate postoperative well-being and clinical progress. In my opinion, however, the best method of decompression is by the use of a small metal tube devised by Dr. Fred R. Fairchild. This tube, 60 centimeters long by .75 centimeter in diameter, with a protected, barred tip, is connected to a suction bottle and passed gently through the various distended intestinal loops. This method avoids the milking process of Holden and others that demand so much manipulation of diseased bowel.

No entero-enterostomy is ever justified except possibly in a very early condition. Any forced excision of bowel, as from gangrene, should be done extra-abdominally, and the loops so placed as to allow an early anastomosis, as by the method of Mikulicz.

To summarize: Employ a sufficiently large incision to allow proper exploration, follow the nondiseased (collapsed) bowel upward to the obstruction, decompress gently, with as little manipulation as possible, and avoid extensive surgery in any distended edematous intestine.

Postoperative Phase. — Attention to the fluid and mineral balance is now of paramount importance. Three per cent saline to 300 cubic centimeters, given intravenously after the surgery, often seems to institute peristalsis and direct the intestinal gradient in the right way. In a moderately severe degree of toxemia from intestinal obstruction, one of the greatest means we have of saving our patient is the continuous intravenous drip, employing such saline preparations as normal saline, Ringer's solution, glucose 5 per cent, in normal saline, or Hartman's solution. As much as six to eight liters in twenty-four hours may be given at a rate of about 120 or less drops per minute. The blood chlorid estimation may be used as a guide. For practical use, the relief of the patient's thirst and the balancing of the output with the intake of fluid may serve as a rough estimation. For the average adult, 3,000 cubic centimeters of fluids or more should be given in the various manners, unless contraindicated by impending pulmonary edema from cardiac decomposition. Too small an amount of fluids given is the most common fault.

The continuation of the gastric lavage, via nasal catheter, may be of value, but the upper gastrointestinal juices should not be removed unless the intestinal gradient is still reversed. Likewise, the loss of upper intestinal content by enterostomy is unwise, and whenever possible it should be shunted into the lower unobstructed bowel.

Of equal importance are: the frequent change of position; the use of large, hot abdominal stupes; the wise employ of morphin for rest; and the *avoidance* of such whips as eserin, pituitary extract, and repeated spinal or splanchnic anesthesia.

The essential points in the treatment of intestinal obstruction, therefore, are: sufficient fluids with the substances to replenish the lost CL ions and minerals; the most gentle and direct surgery to release the obstruction with the least manipulation, and the avoidance of any extensive suturing of diseased bowel.

University of California Men Develop Better Drug for Treating Lepers.—Discovery of a new drug which promises to be highly effective in the treatment of one of the most feared of human diseases, leprosy, has just been announced by the department of pharmacology of the University of California Medical School.

This drug is known as "Na-dichaulmoogryl-B-glycerophosphate," or simply as "Chaulphosphate," and is a derivative of Chaulmoogra oil. Chaulmoogra oil, made from the berries of certain Asiatic plants, has long been recognized as a valuable therapeutic agent in the treatment of leprosy, but difficulty has been encountered in obtaining an active derivative which would be tolerated by the body in adequate doses.

By using a glycerophosphate of Chaulmoogric acid the University men have, apparently, overcome this difficulty. The chief characteristics of the new drug are: solubility in water, suitability for intravenous injections, freedom from toxicity to the body, and a highly destructive action against the "germs" of leprosy.

Preliminary tests of the drug were made on rats, which are subject to a form of leprosy closely similar to that in man. Further tests on human beings will be made this fall at the Oswaldo Cruz Institute of Rio de Janeiro, Brazil, a center for research sponsored by the League of Nations Committee on Leprosy.

The experimental work leading to the discovery of the new chemical was carried out by a young graduate student, George A. Emerson, with the coöperation of Dr. H. H. Anderson, instructor in pharmacology; Dr. A. J. Salle, assistant professor of bacteriology; Dr. Chauncey D. Leake, professor of pharmacology, and Dr. E. L. Walker, professor of tropical medicine.

Emerson and his co-workers have spent two years or more in an investigation of the chemotherapy of leprosy. Selection of the new drug "Chaulphosphate" involved the preparation and testing of thirteen derivatives of Chaulmoogra oil. In addition some two hundred other chemical preparations were tried, among them a number of anilin dyes, metallic compounds, fatty acids, ensymes, protoplasmic poisons, etc. Of these a number have given promising results in the destruction of the lepra bacterium, but must be tested further before being put to clinical trial.

"Chaulphosphate" is the latest of several important drugs developed at the Medical School. Among these have been "Carbarsone," a derivative of arsenic, and "Vioform," a quinin derivative, which have proved to be more effective and less dangerous in the treatment of amebic infections of the human intestinal tract than any other agents yet used.

. . . We do not yet sufficiently realize the truth that as, in this life of ours, the physical underlies the mental, the mental must not be developed at the expense of the physical. . . . (Herbert Spencer, 1860).

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Leaflet Regarding Rules of Publication.— California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

FINAL VOTE ON INITIATIVES 9 (CHIROPRACTIC) AND 17 (NATUROPATHIC)

Final State Election Returns Announced.—In the analysis of the returns of the state election held on November 6 last, and the vote on Initiatives 9 (Chiropractic) and 17 (Naturopathic), which were given on page 410 of the December issue of CALIFORNIA AND WESTERN MEDICINE, it was stated that the incomplete figures used were the initial returns, as printed in the daily press a day or two after the election. On December 15, the Secretary of State gave out the final statistics, and they are here presented for the information and reflection of those many members through whose educational and other efforts the rejection of the two initiatives, and by such imposing majorities, was in large part made possible.

* * *

Adverse Legislation Seems to Be the Order of the Day.—However, significant as was the outcome above noted, the heavy and decisive vote against the measures should not inspire the conclusion that the suggested laws, or any similar propositions, have been permanently shelved. Quite the contrary. In California, as in other states, the appearance and reappeaance of such proposed statutes may be expected at every session of a legislature, and also for balloting in almost every state election, if constitutional provisions in a state make possible the enactment of laws by initiative vote.

To illustrate this point, the American Medical Association *Bulletin* of November, 1934, in a summary by the American Medical Association's Bureau of Legal Medicine and Legislation, printed eight pages of comments on proposed legislation submitted since January 1, 1934, in a large number of states. The *Bulletin* article referred to makes very evident that everywhere there is need of alert and well-considered action by organized medicine, if the interests of the public health are to be properly safeguarded from ill-considered or selfish legislative onslaughts.

* * *

The Official Ballot Figures on Initiatives 9 and 17.—Referring again to the California election returns, Secretary of State Frank C. Jordan announces that 3,140,114 persons were registered in California, and that of these citizens 2,360,916, or practically 75 per cent, went to the polls. To show the relationship between the gubernatorial and initiative returns and the deep interest manifested this year by the electors, the vote for the two leading candidates for governor is also given:

GUBERNATORIAL

Merriam	Sinclair	Total	Merriam's Majority
1,138,620	879,537	2,018,157	259,083

INITIATIVES

No. 9 (Chiropractic):

In favor of	Against	Total	Rejection Majority
662,548	1,082,795	1,745,343	420,247

No. 17 (Naturopathic):

In favor of	Against	Total	Rejection Majority
492,098	1,115,122	1,607,220	623,024

* * *

There Should Be No Let-down in Vigilance.—The perusal of the above figures may lead some members to think that our battles against adverse laws are over, at least for the time. That such reasoning is in error, however, will be sufficiently demonstrated before the beginning of the February recess of the California Legislature. It is quite possible, in fact, that inimical public health legislation will be before us during the next four or five months in such large amount as to demand not less, but increasing vigilance and effort. It is to be hoped, therefore, that every member of the California Medical Association will be alive, as heretofore, to his responsibilities, and will be willing and prepared to give full coöperation when called upon for aid by State and County Society Committees on Public Policy and Legislation.

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

UNIVERSITY PRESIDENTS ENDORSE PROPOSED QUALIFYING CERTIFICATE ACT

Reactions of Presidents Wilbur, Sproul, Millikan, Lyons and von KleinSmid to the Proposed Qualifying Certificate Law.—Basic provisions in the draft of a proposed qualifying certificate (basic science) law were printed, on page 339, in the November number of California and Western Medicine. In the December issue, on page 410, in connection with the discussion of the state election returns on Initiatives 9 (Chiropractic) and 17 (Naturopathic), additional comment was made concerning the need of such a statute in California. In the draft as submitted to the California Medical Association's Council, the suggested board of five qualifying certificate examiners was to consist of one faculty member from each of the following institutions of higher learning: The University of California, Stanford University, the University of Southern California, the University of Santa Clara and the California Institute of Technology. Marked copies of the November issue of California and Western Medicine, with transmittal letters asking them to read the outline of the proposed law, were sent to Presidents Sproul, Wilbur, von KleinSmid, Lyons and Millikan. Members of the Association will be glad to learn consequently, that the purpose of the proposed law received prompt endorsement.

* * *

Excerpts from the Letters Received from the Presidents.—President Ray Lyman Wilbur, of Stanford University, for many years has been a member of the California Medical Association, having started his educational career as lecturer in physiology in Cooper Medical College in 1899, to become, in a few years professor of medicine in the School of Medicine of Stanford University, and later the dean of that institution, and in 1916 president of the University. As an ex-president of the American Medical Association, and as chairman of the American Medical Association Council on Medical Education, he has for years had an intimate knowledge of standards and laws bearing on pre-medical and medical training and licensure, and his point of view, therefore, is of special value. He writes:

"Thank you for your interesting letter of November 28 and the copy of California and Western Medicine, for November, 1934. The plan outlined for a qualifying certificate law as recommended by the special committee meets with my general approval. The idea is not only sound but one that is already in operation elsewhere. California needs it. Stanford University stands ready to do what it can in this connection. We should be glad to be represented on a qualifying certificate board.

"All good wishes."

* * *

In the draft of the law, as presented to the Council by the special committee, it is proposed to have the Regents of the University of California (of which board the Governor of the State is president ex officio), appoint the qualifying certificate board, one from each of the faculties of the five institutions before mentioned. Hence, it is gratifying to know that President Robert G. Sproul expresses his whole-hearted support, as is evidenced by the excerpts from a letter received from him, which reads in part as follows:

"In reply to your letter of November 28, I would make the following comments upon the proposed qualifying certificate law described in the November issue of California and Western Medicine.

"In the first place, I am heartily in accord with what you are attempting to do. It seems to me that it is of the utmost importance that those who are to practice the healing art should have at least a modicum of knowledge of the fundamental sciences which underly it. . . .

"The University of California will, of course, be glad to coöperate in any plan for the improvement of standards which the medical profession may propose and the people of California may approve."

* * *

Dr. Robert A. Millikan, director of the California Institute of Technology, whose researches brought to him a Nobel Prize, replied as follows:

"Upon my return to the laboratory I find certain correspondence from you and a copy of articles by you in California and Western Medicine. I am very glad to express myself as Presidents Sproul and Wilbur have already done as being in sympathy with the purposes as expressed in these articles. I can also say that the California Institute of Technology would 'be glad to coöperate,' as President Sproul has expressed it, 'in any plan for the improvement of standards which the medical profession may propose and the people of California may approve.'"

* * *

President James J. Lyons of the University of Santa Clara, in his reply letter, stated:

"Pardon my tardiness in acknowledging your letters and the copy of California and Western Medicine.

"I have perused the marked article and highly commend the plan proposed. Not only California, but the entire country needs it. We are behind other nations in 'stepping up' the professions. Too many students in this country have not a clear idea of what is expected of them not only in the medical field, but in the professions in general. I have heard European medical experts give our medical students the palm for practical things but deplored the weakness of their 'theory.' A thorough knowledge of all the underlying sciences will enable our practical students to be more skillful according to the best standards.

"I heartily endorse any plan that will elevate the standards of medicine and keep it deserving of its ancient appellation, the *art* of healing."

* * *

The last letter received was from President Rufus von KleinSmid of the University of Southern California, from which we quote:

"Acknowledging receipt of your letter concerning the proposed Qualifying Certificate Act, let me say that we are genuinely in sympathy with any legislation which would tend to raise the standards of the professions. We should be glad to join with other institutions in a movement to standardize to a degree procedures on a high level. Awaiting developments in this matter with interest." . . .

* * *

From the above it is apparent that the framework of the initial draft of the law, as presented to the California Medical Association's Council,

is basically sound. With this knowledge at hand, the elaboration of detail in the act offered for adoption can go forward with considerable assurance.

Members of the Association are again reminded of the invitation expressed in previous comments, that any modifications or criticisms of the proposed law will be cordially welcomed; and such suggestions can be sent to the editor, who has been serving as the chairman of the special committee.

COUNTY HOSPITALS SHOULD PRINT ANNUAL REPORTS

The Massive Donation of Gratuitous Professional Services in County Hospitals.—In large metropolitan institutions for the care of the poor sick, such as the hospitals of San Francisco and Los Angeles counties, the number of patient visits and of major and minor surgical procedures made by attending staff members, who give gratuitous service to the institutions, is very large. For example, at the Los Angeles County Hospital,* for the fiscal year, July, 1933, to July, 1934, the total number of patients admitted were 48,849; the total number of patient days being 706,938, or an average of 14.4 days per patient. On the surgical services of the institution were listed 18,746 patients, and 9,309 operations were done. In addition to the large number of in-patients above mentioned, the out-patient service for ambulatory cases recorded a total number of 507,432 out-patient visits for the year, or about 1,390 out-patient visits per day. While it is true that the Los Angeles County Hospital has a large resident staff (about 125 internes, who are nearly always in residence), the great majority of the 48,849 hospital patients admitted during the last fiscal year were seen by members of the attending staff, and most of the major operative work was done by the attending surgeons. With a record of 706,938 in-patient days and a total of 9,309 operations, plus a total of 507,432 out-patient visits, to cover a period of twelve months, it is self-evident that the attending staff members, when they rendered that amount of gratuitous service, gave to the taxpayers of Los Angeles County nothing less than a massive donation. In terms of money, and at less than minimum fee table rates, the services thus donated would have an annual value of much more than one million dollars!—quite a contribution, and far in excess of what any other group of citizens donated to the taxpayers during the last year. In San Francisco and other counties of California similar expressions of altruistic medical service have also been in evidence from the time that the county hospitals were first established. It is good both to remember and to occasionally mention these facts when criticisms and attacks by salaried social service and so-called welfare experts are made against the medical fraternity and the manner under which its members so unpretentiously do their work.

* * *

County Hospitals Should Print Annual Reports, with Money Evaluations of Professional Services Rendered.—Our special purpose in presenting the above summary is to emphasize the thought that when a group of citizens, such as an attending staff of a large public county hospital, each year give to the poor their professional services, amounting to hundreds of thousands of dollars and without cost to the other taxpayers (who, however, themselves charge for everything they sell or do for the hospital or its patients), then in decency the least that the community should do would be to publish and distribute to civic organizations a printed report putting on record the professional services so rendered, and placing their money values squarely before the consideration of the people. Poor as some of the countries in Europe are supposed to be, they do provide funds for the publication of just such detailed reports of their hospitals, and the unselfish work of their respective staffs.

* * *

Non-existence of Such Printed Reports Responsible in Part for Lack of Appreciation of Altruistic Services Generously Rendered by the Medical Profession.—We are very much of the opinion that if in public hospitals of the United States in which attending staffs give, and give largely, such professional services, it had been stipulated from the beginning, as one of the conditions for the giving of such unrecompensed service, that each institution should print an annual report in which the total money value of the professional services was indicated, then many members of the lay public and taxpayers would be more appreciative of what scientific medicine has been doing for their respective communities; and they would be far less than at the present in the mood to listen to specious reasoning and the vagaries of those who, misguided by insufficient appreciation of either the important professional or economic backgrounds involved, are insisting, with unseemly haste, on legislation leading nowhere unless to confusion.

* * *

Attending Staffs and County Medical Societies Should Give This Subject Their Attention.—For these and other reasons, the thought is suggested to attending staffs of county hospitals and to the respective county medical associations, that an effort might well be made to have every county hospital in California, through authorization by the board of supervisors, print an annual report; with statements therein, not only of the nature of professional services gratuitously rendered, but of the actual value of such donations expressed in terms of the world's money. Such reports would be of interest to many, and only good could result from the needed publicity.

* The "Los Angeles County Hospital" is the medical unit of the "Los Angeles County General Hospital," as explained in the December CALIFORNIA AND WESTERN MEDICINE, page 413.

EDITORIAL COMMENT*

OUR KNOWLEDGE OF X-RAY EFFECTS IN THERAPY

The increasing use of x-rays, not only in diagnosis but also in therapy, has led many physicians to ask what are their effects, and how do they work? The use of the x-ray in diagnosis was based on an accidental discovery, and its introduction into therapy was purely empirical in nature. Those of us who have made a study of its uses have seen that it profoundly affects some malignant tissues, resulting in complete disappearances; while in other types of cancer no visual changes have been noted. This led to the terms of radiosensitive, or radioresistant, as applied to tumors which have been treated. Clinicians and pathologists have ascribed many changes to the direct alteration of the capillaries, with resultant fibrosis and endarteritis. These are end-results and do not necessarily tell us how x-radiation does its work. With knowledge accumulated over thirty years of observation, biophysicists have arrayed themselves into two schools: those who believe that there is a direct effect upon the cell attacked, and those who think that the effect upon the tumor cell is an indirect one, resulting from changes taking place in the tumor base itself. The celebrated tumor pathologist, Ewing, in a Caldwell Lecture, made the statement that radium exerts its maximum effect on epithelial cells directly, while x-rays act upon the connective tissue supporting the framework of the carcinoma, choking out the vagrant epithelial tumor cells by fibrosis. This statement has led to the erroneous assumption that radium and x-rays differ in their effects, disregarding such pertinent facts as the difference of time and filtration.

At a recent lecture in London, Coutard gives an excellent summary of this vexing problem. Coutard is a veteran in radiation therapy, for he has been associated with Regaud in the Curie Foundation in Paris, where an extended research has been going on for the last twenty years. He agrees with the two schools, of the direct and indirect effects, and gives reasons which are very plausible. In the embryonic or so-called radiosensitive lesion, the energy factor is the important thing to consider. Here the effect is directly on the nucleus of the cell itself, profoundly producing metabolic changes which result in early death of the cell. We see this in lymphosarcoma and in the enlarged thymus of the new-born. In the highly differentiated or radioresistant carcinomas, the energy factor is of secondary importance, while the time factor is predominant. In other words, the radiation is more feeble, but must be continued over a long period of time. The cancer cell absorbs the energy slowly, with a resultant radio-evolutionary change taking place from indirect action on the connective tissue-supporting structure. When the treatment is given too rapidly there are capillary vascular changes in this tumor bed, with resultant edema. If this takes place we say that the tissues are radiation-fast, and if more treatment is given the effects are detrimental to the patient, for the connective tissue framework breaks down and the cancer cell keeps on growing rapidly. In simple words, the treatment of radioresistant or highly differentiated malignancies is an attempt to produce an aging evolutionary change in the cancer cell and to have it die a natural death, leaving a normal supporting structure. Such an accomplishment is extremely difficult of attainment, but has apparently been carried out by Coutard. This evolutionary or aging effect produced by the x-rays is not a new idea; a few years ago Isaacs, working on leukemia at the University of Michigan, made the observation that the improvement in the patients and in their blood counts with this disease treated by the x-ray was due to the fact that radiation caused the immature cells in the circulation to mature more rapidly and to be thrown out of the blood stream through the salivary and intestinal secretions.

Radiation therapy in cancer is comparatively new. The technique is not stabilized or standardized, as is surgical technique. Such contributions as those of Coutard will tend to individualize the treatment by correlating the technique with the pathological picture. Oftentimes a patient will be referred to the therapeutic radiologist with the request that he be given a "shot or two of x-ray." In the light of the foregoing, such requests are absurd; one or two treatments may be of benefit, but for possible curative effects it is necessary that treatment be given over a period of time. The cost of therapy rises because of this time element, but this should be of secondary importance if the patient recovers.

1407 South Hope Street.

Orville N. Meland,
Los Angeles.

ANTIHORMONES AND AUTOCYTOTOXINS

Thus far the main criticisms of the present enthusiastic use of "hormones" in clinical medicine have been based on lack of knowledge as to the nature, function and interrelationship of normal internal secretions, and on fear of causing undesirable perversions of existing endocrine functions. The Council on Pharmacy and Chemistry of the American Medical Association,[1] for example, recently warned clinicians against overenthusiasm in its statement that "clinical use—has kept far ahead of laboratory data." The Council, however, failed to emphasize the fact that many available laboratory data, suggesting limitations and dangers in endocrine therapy, are apparently unknown or ignored in practical clinical therapy.

Among laboratory data of this type none is of more fundamental clinical importance than the evidence that all therapeutic "hormones" and endocrine products thus far adequately tested are specifically antigenic for laboratory animals, *i. e.*, capable of stimulating the production of apparently specific antihormonal immunities. Hormonal antigenicity, for instance, was reported six years

* This department of California and Western Medicine presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 J. A. M. A., 100:1331, 1933.

ago by Doctors Sahyun and Blatherwick,[2] who found that repeated injections of insulin into rabbits soon render these animals highly refractory to insulin therapy, and that their insulin-immune rabbits were often able to withstand intraperitoneal injections of from thirty to fifty times the minimum lethal dose of insulin for normal rabbits.

Doctor Selye and his associates,[3] of the Department of Biochemistry, McGill University, have recently reported a similar antigenicity for the anterior pituitary-like hormone in pregnancy urine. In many of their pituitary-immunized rats the ovaries were atrophic or degenerate, strongly suggesting that the antipituitary-immunity functions as an immunological "vicious circle" in rats, specifically inhibiting or depressing the animals' own ovarian functions.

In rats receiving repeated implants of hypophyseal tissues, Doctor Collip and his associates[4] of McGill University, have more recently demonstrated a specific antihypophyseal immunity sufficient to render the animals refractory to one hundred times the normal therapeutic dose of the thyrotropic hormone. In these immune rats the normal metabolic rate was often decreased from 20 per cent to 40 per cent, approximately to the level of control hypophysectomized rats. This is apparently due to an immunological vicious circle, completely inhibiting or inactivating the animals' own hypophyseal function.

That such vicious circles are due to circulating antibodies is shown by the fact that normal rats can be passively immunized against multitherapeutic doses of the thyrotropic hormone, and even against their own hypophyseal internal secretion, by a serum transfer from an hypophysis-immune rat. The antihypophyseal serum factor will also neutralize the thyrotropic hormone *in vitro*.

Stanford University.

W. H. Manwaring, Palo Alto.

OPERATIVE DELIVERY AND FETAL MORTALITY

An active campaign has long been in progress to lower maternal and fetal mortality. It has been demonstrated repeatedly that the high fetal death rate is in a large measure due to injudicious and unskillful operative interference. The older, as well as the more recent literature, is replete with elaborate reports showing that fetal mortality invariably rises with an increase in the incidence of operative delivery. The lessons taught by these studies have thus far not been productive of very striking results.

Recent reports show that there is still an unjustifiably high incidence of forceps delivery, and breech extraction, and that this operative interference is associated with serious injury to the fetus, and with a high fetal mortality.

In a statistical study of 129,539 births registered in Iowa during the past three years, Plass and Alvis[1] found an operative incidence of 11.8 per cent. The stillbirth rate in the spontaneous deliveries was only 2.0 per cent; and in breech extraction, and version and extraction, the mortality rose to 11.0 per cent and 19.6 per cent, respectively. The average stillbirth rate for the operative deliveries was four times higher than for the spontaneous births.

A recent report by Gordon, Garlick, and Oginz[2] shows clearly that in breech presentation the fetal mortality increases greatly with the extent of operative intervention. An analysis of 3,301 breech deliveries in the hospitals of Brooklyn during the five-year period ending in 1930, revealed the following facts:

1. In 1,597 cases of spontaneous and assisted delivery, the fetal mortality rate was 6.7 per cent; thirty-two babies (2.0 per cent) were injured.
2. In 555 cases of breech extraction, the fetal mortality rate was 18.7 per cent; twenty-eight babies (5.0 per cent) were injured.
3. In 405 cases in which the breech was broken up, the fetal mortality rose to 28.9 per cent; forty babies (9.9 per cent) were injured.

The foregoing data clearly demonstrate what has long been known, namely, that operative intervention inevitably results in a rise in fetal mortality. The statistics presented are particularly enlightening in that they portray the present-day obstetric practice of the average physician in both rural and urban communities. They show that both the general practitioner and the specialist are much too ready to interfere with the normal processes of labor.

Many practitioners apparently do not understand that operative intervention inevitably introduces pathologic processes into the normal mechanism of labor. They do not fully appreciate that the mechanism of labor is a very intricate process which cannot be imitated closely by any artificial means; and that the obstetric forceps even in skillful hands, and under the most favorable circumstances, is but a poor substitute for the normal powers of labor. Many physicians are unaware of the fact that the breaking up of a breech followed by hasty traction is very apt to result in extension of the arms and in deflection of the head. If the practitioner will fully realize that "assistance" in normal labor is merely an interference with, and a hindrance to a normal process, he will curb his earnest desire to help his patient, until compelling indications develop for operative intervention.

A policy of strict conservatism followed blindly will, however, occasionally lead to disaster. The physician must possess mature judgment to know when operative intervention is unavoidable, and he must likewise possess the necessary skill to carry out the operative procedure which may be indicated. A reduction in fetal mortality incident to operative delivery is not to be hoped for until the practitioner will realize that major obstetric operations are highly specialized surgical procedures, demanding clinical wisdom and manual dexterity which can only be acquired through long training and experience.

1009 Medico-Dental Building.

Samuel Hanson, Stockton.

2 Sahyun, M., and Blatherwick, N. R.: J. Biol. Chem., 79:443, 1928.

3 Selye, H., et al.: Proc. Soc. Exper. Biol. and Med., 31:487, 566, 113, 1934.

4 Collip, J. B., et al.: Lancet, 1:76, 784, 1934; J. Mt. Sinai Hospital, 1:28, 1934.

1 Plass, E. D., and Alvis, H. J.: Am. Jour. Obst. and Gynec., 28:293, 1934.

2 Gordon, Charles A., Garlick, Ralph, and Oginz, Philip: Am. Jour. Obst. and Gynec., 28:140, 1934.

CALIFORNIA MEDICAL ASSOCIATION

FREDERICK C. WARNSHUIS, M. D., Associate Editor for California

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

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ROBERT A. PEERS.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

MONTH'S ACTIVITIES

Dr. Robert T. Legge, chairman of the Extension Lecture Committee, and the secretary conferred with the deans of medical schools in the southern part of the State on November 23. Plans were developed for postgraduate work. See further reports elsewhere in this department.

* * *

Membership certificates will replace the member's pocket card. Upon receipt, members are urged to frame their certificate and hang it in their reception room. This will cause your patients to be reminded that there is a medical society in your county and that you are a member. Early payment of your annual dues will bring this certificate to you this month.

* * *

Some 460 persons were engaged in the State survey that is being made under the supervision of the Committee of Five.

* * *

Conferences were had with the SERA administrator for the purpose of securing a State uniform plan for medical care. The proposed plan and details will be imparted to county societies when perfected.

* * *

Right here we pause and draw attention to our advertisers. These firms make your JOURNAL possible. They merit your patronage and preference. Please accord it.

* * *

Take that new calendar or engagement book. Turn to the dates of May 13 to 16 and mark them, for those are the days you plan to attend the annual session in the Yosemite National Park.

* * *

Your State Secretary attended the county meetings at Yuba, Riverside, San Bernardino, Napa, Marin, and Santa Barbara. Visits are being made to county societies as the other duties of office permit.

* * *

Efficient Organization.—"In various quarters there is agitation for radical changes in medical practice, and the need for efficient organization is greater than ever before." In the formulation of policies, guidance is sought from recognized authorities. In affairs medical and those related to public health, our county, state, and national medical organizations are the recognized authorities who speak and act for the profession. Every eligible physician should affiliate with these representative bodies that conserve his interests. Every member should seek to secure the affiliation of every eligible physician in his county. Induce him to join at the beginning of this new year.

Reference Library.—We are gradually acquiring a reference library of authentic texts on medical education, hospitals, legislation, public health, and medical economics. This information is at the disposal of our members. Your inquiries will be welcome.

* * *

Information to County Societies.—An endeavor is being made to promptly transmit, by means of communications addressed to county secretaries, the latest developments in Federal and State activities related to legislation and medical economics. If you desire to learn about what is happening, attend the meeting of your county society, where this information will be imparted to those in attendance.

* * *

Council Meeting.—See this issue for the minutes of the Council and important action recorded. The Council met on December 22 and 23, during which session conferences were had with the Senate's Interim Committee and the Association's Committee of Five. At the regular meeting of the Council, to be held on January 19, a decision will be made as to a date for the special meeting of the House of Delegates.

* * *

SERA Medical Relief.—The Association's Advisory Committee to the SERA director has had several conferences with the State Director. A State plan for providing medical care is in process of formation. The completed plan will be sent to county societies early in January.

* * *

Annual Dues.—Placer County is the first county to remit 1935 annual dues for all of its members. This splendid example should inspire members to promptly remit their 1935 dues to their county secretaries.

STATE AND COUNTY SOCIETY ACTIVITIES

POSTGRADUATE STUDY

These startling facts were uncovered in a recent survey of physicians in three states:

It was found that nearly 42 per cent of the physicians in the group were deficient in medical knowledge. It was found that only about 29 per cent of the physicians engaged in postgraduate study during a ten-year period for an average time of less than a week per year, that about one-third engaged in less than three weeks in ten years and that 40 per cent attended less than six medical meetings a year, that 15 per cent did not participate in any session whatever.

It has often been said that a physician who has taken no graduate work for five years may still catch up; after ten years only the exceptional man can reach the advancing front and after fifteen years he is almost hopelessly behind.

It is for this reason that the California Medical Association is actively engaged in making postgraduate opportunities available to its members. The medical schools of California are subscribing their valuable assistance and coöperation.

AMERICAN MEDICAL ASSOCIATION FELLOWSHIP

Several inquiries have been received asking the difference between American Medical Association membership and fellowship.

By virtue of one's membership in a county and state medical organization, the individual automatically becomes a member of the American Medical Association. To become a Fellow, one must file an application and pay the annual fellowship dues of $7.

The benefits of fellowship are: A copy of *The Journal of the American Medical Association* (weekly), right to attend the annual meeting, eligible to present papers and enter in the discussions of the sections, and lending support to national activities.

Many members subscribe to *The Journal of the American Medical Association* and pay the annual subscription price of $7. These subscribers are under the impression that they are Fellows because of their subscription. They are in error. It is recommended that if you are a subscriber and never filled out a fellowship application that you do so. The cost is the same; in addition you will obtain all the fellowship benefits, which includes the *Journal*. If two or three doctors are associated, you can elect to receive one of the Association's special journals, thereby receiving one *Journal of the American Medical Association* and one or more of the special journals in your office. You owe it to yourself to become a Fellow of the American Medical Association.

* * *

LEGAL SERVICES

The attention of our members is again directed to the legal services that are made available to them by the medical society of the State of California. By becoming a member of this suborganization of the State Association you secure the services of legal counsel in any action brought against you on the grounds of malpractice. The annual membership dues are $10.

Members are urged to obtain this legal protection. Should an action be commenced against you, much peace of mind will be yours by reason of this legal protection. Write for an application blank today.

* * *

SAN BERNARDINO SERA AGREEMENT

At the December meeting the final plan for medical SERA work was presented in the form of "Medical Bulletin No. 1."

Your committee believes that this fulfills the "Declaration of Policy" printed in the December Bulletin, and bespeaks hearty and sympathetic coöperation to make this plan a success.

Our county is pioneering somewhat in this line of endeavor, and the success or failure of the plan will affect not only our county, but will undoubtedly be closely watched by other sections. We, therefore, are bearing a more than local responsibility and must pull together in a helpful spirit to work it out successfully. The failure of the plan will undoubtedly prove a strong argument for public clinics and lay-controlled medicine.

Medical Director.

A full-time medical director has been appointed and will have his office in the SERA headquarters, 1140 E Street, San Bernardino, where he may be reached by telephone or letter, and to him should be directed all questions as to medical policy. If such questions require further decision, they will be taken up by him with your Medical Committee and the county medical society as a final authority in consultation with the SERA administrator.

Medical Care.—The funds for medical care will be very limited and must be spread over the patients where the most good will be done with the available funds. It will be necessary then to hold very strictly to the limitations and not enter into the treatment of chronics which would be prolonged, expensive, and of doubtful efficiency, thereby depriving some patients of relief of acute conditions through early exhaustion of available funds. We ask your coöperation in this feature of the plan.

The panel of physicians available for this work is made up by taking the complete membership of the San Bernardino County Medical Society as a panel. If you do not care to do any of this work or will restrict your work to some of the specialties, please notify the medical director to that effect, as otherwise your name will appear on the panel for "all medical work," until the medical director has been notified to the contrary.

The prospective patient will be asked by the local district director or the medical director if he has a family physician, and if so, and he is available without mileage, or is willing to forego mileage if too far away, the patient will be sent to his family physician. If he has no family physician, he will be assigned to the medical list in rotation, with due consideration of mileage problem.

Routine Procedure.—It is absolutely necessary that "reports" be made promptly and thoroughly. Failure to comply will certainly be considered cause for removal of a name from the panel.

MEDICINE AND MEDICAL SUPPLIES

The local administrator has assured us that emergency dispensing of simple inexpensive drugs from the doctor's own supply will be recognized as a just charge if specified and itemized on the doctor's bill for services. In general it may be said that the billing and use of expensive or excessive drugs and dressings will call for careful scrutiny on the part of the medical director and the committee.

Fee Schedule.—We believe that the schedule submitted is eminently fair and should provide the patient with "adequate and efficient medical care" at the price to be paid the physician. Any abuse of this privilege will call for most drastic action on the part of the director and the committee, with an added possible charge of non-professional and non-ethical conduct before the Committee on Professional Conduct of the County Medical Society.

Your committee has met with the most wholehearted coöperation and sympathetic understanding on the part of Mr. Thoreson and Mrs. Fleming, and we beg your heartiest coöperation to make the plan a success. Constructive criticism and helpful suggestions will be most gratefully received.

Fraternally yours,

C. G. Hilliard
Calvert L. Emmons
Eugene H. Hull
Medical Advisory Committee to the SERA.

* * *

State of California Emergency Relief Administration
County of San Bernardino

December 1, 1934.

MEDICAL BULLETIN NO. 1

County Emergency Relief Committee.

The San Bernardino County Emergency Relief Committee was selected jointly with the approval of the Board of Supervisors and the State Emergency Relief Commission and set up to carry out Federal and State policies within this county.

County Medical Committee.

A county Medical Committee has been formed by the County Medical Association to assist in formulating a program of medical care for SERA clients. This committee will work in coöperation with the County Emergency Relief Committee and the SERA Administration.

Medical Director.

A full-time medical director will be selected by the County Medical Committee and in turn approved by the County Emergency Relief Committee. This medical director will direct the medical program and will work in coöperation with the Medical Committee and County Emergency Relief Committee.

Until further notice, it is to be understood that the following regulations are to be used as a guide in conjunction with Federal rules and regulations contained in Bulletin No. 7.

Medical Care.—Medical care shall not ordinarily be authorized by a relief administration for conditions which do not cause acute suffering, interfere with earning capacity, endanger life or threaten some permanent new handicap which is preventable where medical care is sought, medical care may be prescribed for patients on

unemployment relief by any person who is a member of the county medical society, and whose name appears upon the approved medical panel.

Routine Procedure.—Authorization of medical care for patients may be given only by district case supervisors or by the medical director. First authorization will be in the form of a reference slip. In cases of emergency it will be permissible to get authorization over telephone from either district case supervisor or medical director.

Upon receipt of authorization, and immediately after first visit to the patient, physician shall fill out form No. 112, indicating (a) tentative diagnosis; (b) recommendation for clinic, hospital, or home care; (c) if home care, the estimated duration of the illness and probable number of visits required.

On Saturday of each week physicians will complete "Physicians' Weekly Report," filling in all information requested and mailing the same to 1140 E Street, San Bernardino. (Attention, Medical Director: This weekly report is possibly the most important step in the routine procedure of our medical program. The success or failure of the program depends entirely on the integrity of the physicians filling out this report. These reports will all be checked very carefully by the medical director, and if questioned, final decision will rest with the Medical Committee.)

Upon receipt of physicians' weekly report, district case supervisors will be notified to issue Disbursing Order Form No. 166 for week's services to each patient, and send the same to the physician by client.

The client will hand Disbursing Order No. 166 in duplicate to the physician, who makes out bill on the reverse of the disbursing order, and have the patient sign the same. If a child, then either parent may sign.

When disbursing order is thus completed, it should be mailed to 1140 E Street. (Attention, Medical Director: Physician should always keep second copy of disbursing order as a memorandum or book account.)

Checks sent to physicians will be accompanied by a transmittal, showing numbers of disbursing orders covered by check. In this manner, physician's file of unpaid disbursing orders should be accounts outstanding.

MEDICINE AND MEDICAL SUPPLIES

Authorization for medicine and medical supplies shall be restricted to the simplest of emergency needs of the patient, and in general shall be issued only upon the written request of the physician in charge. Patients or representative of patients will call at district case supervisors' office or medical director's office, presenting written request of physician for the same. Case supervisor or medical director will write a disbursing order on the client's choice of drug store, and the client will in turn present the same at drug store for merchandise.

Maximum prices shall be based on the Pacific Drug Review price schedule, minus 25 per cent, with the understanding that the least expensive drugs shall be used wherever possible.

The druggist shall list on reverse of disbursement order the name and quantity and price of drug. The formulae and number of each prescription costing more than 25 cents shall be submitted with or made a part of the pharmacist's bill.

Special Service.—(1) Bills for special service shall give full details of such services. (2) Fees for major or minor operations must all be passed by the Medical Committee.

Fee Schedule.—Maximum fees charged for attendance at home of those on relief will be allowed as follows: 6 a. m. to 9 p. m. and 9 p. m. to 6 a. m., $2.50. Visits beyond city or town limits, 6 a. m. to 9 p. m., 50 cents per mile one way, and $2.50. Visits beyond city or town limits, 9 p. m. to 6 a. m., 75 cents per mile one way, and $2.50. Each extra patient seen on visit, no mileage and one-half the charge for a home visit. (To include ordinary examination, necessary blood count, urinary examination, treatment, and minor surgical dressing, first office visit, $2.50; subsequent, $1.25.)

Where the problem of home obstetrics arises, a fee of $25 may be paid to cover prenatal, delivery and postnatal care. (Note Form 112.)

It is assumed that prenatal care will consist of a physical examination on the patient's first visit and not less than a monthly blood pressure determination and urinalysis until the end of the seventh month, and a bimonthly blood pressure determination and urinalysis during the last two months.

Delivery under this plan will be accomplished at home.

Postnatal care will consist of not less than two visits by the physician, one shortly after delivery and one before permitting the patient to leave her bed and whatever other visits are reasonably necessary in the particular case.

INFORMATION FOR PHYSICIANS ON SERA NURSING PROJECTS

This project is set up for unemployed graduate and practical nurses in cities and towns of San Bernardino County and is designed to serve only families on the SERA or County Welfare Department.

In every community there are persons who are charges of the SERA and county welfare who are ill and require hourly or full-time nursing service for a short period of time. Some of these persons are acutely ill and may need special treatment. Some not acutely ill, or convalescent as postoperative, maternity cases delivered in the home, or newly discharged from the hospital, chronics (arthritis, paralysis, cancer, heart disease, tuberculosis), could be served by SERA nurses on a part-time basis, and would be greatly benefited by one, two, three or more hours of nursing care.

Physicians of San Bernardino County are requested to call the SERA where such nursing service is needed. A nurse will be sent only in response to the call of a physician, and nursing care will be given only under the orders of a physician.

Written instructions for the nurse should be left at the home by the attending physician, and nurses are instructed to carry out only the treatment and medication as prescribed by the doctor.

The hours the nurse is to remain at the patient's home and when the service is to terminate should be given by the physician to SERA headquarters.

Physicians will telephone the Social Service Exchange, telephone 5171, at the SERA headquarters when in need of an SERA nurse. Calls can be placed from 9 a. m. until 5 p. m., Sundays excluded. Before and after the above hours and on Sundays, telephone 39L-88.

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EXTENSION LECTURES POSTGRADUATE SERVICE

To the Members of the County Medical Societies:

For several years the Committee on Extension Lectures of the California Medical Association have secured and listed a number of representative medical men who were willing, when invited, to serve on programs for our county medical societies and who had prepared papers on scientific and practical medicine.

Your committee, in making its annual report to the State Society, has submitted plans and offered suggestions to arouse interest in the developing of a practical postgraduate service covering the newer developments in medicine and public health, which will be brought to the medical profession in the various councilor districts of the State.

We have also suggested that the four regular medical colleges in our State be persuaded to prepare and arrange clinics, demonstrations, and lectures for the regular medical profession in graduate work.

It was also suggested that a page in our JOURNAL be devoted to educational and extension service so as to keep our county societies, hospitals, clinics, and members informed regarding coming events, extension lectures, scientific movies, visiting lectures, alumni and university clinics, broadcasts, etc. This page is to be assured by the editor of the JOURNAL, and copies in the form of reprints can be secured by interested groups, to be posted on their bulletin boards.

Another important feature of extension service is the developing of a medical library service for physicians, enabling them to obtain journals, books, reprints, and bibliographies for study and preparation of medical papers. The State medical libraries at the University of California at San Francisco and at Los Angeles, as well as the Stanford University library at San Francisco, are offering such a service. The cost of mailing and preparing package material is to be defrayed by the physician.

We have recommended that whenever a postgraduate one-day county clinic or a more intensive course is held, that a public lecture before a lay group be given on medical economics, public health or popular medical education. The value of such a lecture in these days of changing events can be fully appreciated.

At present, Wisconsin, Michigan, Tennessee, and Massachusetts are offering their physicians opportunities to receive postgraduate courses in their home communities. Funds have been provided by the legislature in Wisconsin for such a service so that rural physicians may have the opportunity of practicing up-to-date medicine. The state societies are also providing funds and doing all in their power to promote such graduate extension courses. In most of the districts the county societies and the physicians are assessing themselves a sum sufficient to pay the traveling expenses and a small honorarium to the men programmed. The hospital clinics are provided by the local society or medical group.

The Council at one of their annual meetings, 1931, discussed a plan for postgraduate work, submitted by Dean Langley Porter of the University of California.

A resolution was adopted endorsing the plan and commending it to the California Medical Association and its component county societies.

During the past two years the University of California Medical School has established, at the request of local physicians in northern California, local postgraduate sessions. These sessions are planned to give yearly, at a center in each district, twelve sessions of three meetings each. Already seven districts have been outlined in northern California, where the work is being carried on.

Dean Porter stated that the fundamental part of this postgraduate work depends upon our large and well-established consultation service for physicians. This service has now been going on for two years. Out of this service grew the demand from physicians in different parts of the State for these local postgraduate sessions at which the more interesting problems could be discussed at length with groups of physicians in the patient's own home community.

President Robert G. Sproul feels that to give this service to the people of the State, through their own physicians, is the distinct duty of the University. The president has laid down as fundamental that the duty of the Medical School to the community does not cease when it has graduated a group of well-trained medical men; he holds it to be equally the responsibility of the University to bring to practicing physicians in their own communities the latest and most authoritative developments in diagnosis and treatment. The president also announced as his belief that no greater calamity could befall any community than to have the economic and moral authority of the family physician broken down. For this reason the Medical School administration takes the utmost care to reject for this consultative clinic all such patients as, in the opinion of the referring physicians and the social service department of the University of California Medical School, are able to pay the necessary fees to a consultant.

Dean Porter feels thoroughly that if the State Society can coördinate, organize and encourage these activities that the real value of scientific and up-to-date medicine can be so demonstrated that the inferior medical service of the cultists, to whom so many people now turn, will lose any appeal it may have for the public; and that we will be able to help establish scientific medicine without any important rivals in the State of California.

Your chairman, Dr. R. T. Legge, called a meeting at San Francisco in October to discuss with the new secretary, Dr. F. C. Warnshuis, postgraduate extension courses. Present at this meeting were Dean Langley Porter and Dr. W. E. Carter of the University of California Medical School. Unfortunately Doctor Chamberlain of the Stanford University Medical School was unable to attend. At this meeting the Wisconsin, Michigan, and California plans were discussed. The University of California has developed successfully and is well organized. Dean Porter feels that the diagnostic service is the heart of a practical postgraduate extension course. He is firmly convinced that postgraduate service tends to improve the solidarity, moral and economic, of the profession of the State. The problems of reaching out to all the councilor districts of the State, interesting the staff of our teaching colleges and hospital, securing support from the legislature, medical societies, foundations, etc., were discussed.

It was agreed that the chairman and Dr. J. H. Churchill of San Diego call a meeting at Los Angeles on November 23, 1934, at the Los Angeles Medical Society building and have present Dean P. S. McKibben of the University of Southern California Medical School, Dr. Newton G. Evans of the College of Medical Evangelists; Dr. F. C. Warnshuis, secretary of the State Medical Association; Dr. George H. Kress, editor of California and Western Medicine; and President Clarence Toland.

The main object was to secure the coöperation and assurance from the two undergraduate medical schools in the south for the establishing in the councilor districts south of the Tehachapi of postgraduate extension courses similar to the plan of the University of California in the north. Dean McKibben stated that his school receives many inquiries for such a course. He assured the committee that the University of Southern California was willing to coöperate with the State Medical Association and the Extension Lecture Committee in offering such courses. Doctor Evans was also much interested and heartily approved of the idea. They will meet with Doctor Churchill shortly to perfect the plans. Doctor Legge assured them that Dean Porter would offer the services of Dr. W. E. Carter of the University of California, who would go to Los Angeles to assist in their organization, and would be willing to send clinicians if necessary. Dr. George Kress stated that the State Medical Library had over eight hundred contacts with physicians. President Toland was much impressed with the progress made in postgraduate extension work and believed it would meet with the hearty approval of the profession of the State.

The California Medical Association at its last meeting established a budget of $1,500 to further this important service to its membership.

The Committee on Extension Lectures is very much gratified with the progress made in postgraduate education, and with the cordial coöperation of the medical schools, the splendid support given by the president and the secretary of the California Medical Association, and the welcome tendered by the profession of the State.

Respectfully submitted,

Robert T. Legge, *Chairman*
J. F. Churchill
J. Homer Woolsey

* * *

To Robert T. Legge,
Chairman, Extension Lecture Committee,
Berkeley, California.

The University of California Medical School has developed a plan for extra-mutual teaching in medicine. Postgraduate sessions are to be held in different localities in the northern part of the State. Already in each of seven districts a local postgraduate unit has been established. These districts are as follows:

1. The northern counties, centering about Eureka.
2. The central counties, centering about Chico.
3. The central counties, centering about Santa Rosa.
4. The central counties, centering about Sacramento.
5. The central counties, centering about Oakland.
6. The central counties, centering about San Jose.
7. The central counties, centering about Fresno.

For several years the University of California Hospital and Medical School has conducted a diagnostic service for physicians to which physicians could send patients whom they believed unable to pay an acceptable fee to a consultant. The social service department of the Medical School rigidly checked the status of these patients, and such as were found to have misled their physicians in regard to their financial status after consultation with their doctor were excluded.

The patients admitted to this diagnostic clinic are given thorough and intensive study by various members of the teaching staff of the Medical School. Complete reports of the findings are made and these are sent to the referring doctor and the patient is returned to him for further care. If the physician indicates his wish for advice about the treatment, this is also sent.

The procedure has proved to be of great advantage to the referring physicians in that it constitutes a practical form of postgraduate instruction, and in that it maintains the patient-physician relationship. Furthermore, it increases the authority of scientific medicine because it gives to the patient the understanding that their local physician has free access to the aid of highly trained specialists and through them the use of the modern and effective equipment for study of disease of a great hospital.

From their experience with this service the practitioners who used it came to demand that the ex-

tension of University teaching facilities be made available to practitioners in their home districts. It was natural that the University authorities would meet this demand of the practicing physicians with sympathy, for the extramural services of the University, especially those of the College of Agriculture and of the Hooper Foundation for Medical Research, have been well organized and of enormous value to the State for many years. The service of the Hooper Foundation, through the coöperation with the State and local health departments, has been of a value almost beyond computation.

The extramural medical teaching program is organized so that sessions are held in each of the districts twice each month on alternate Fridays and Saturdays. The Friday meetings are devoted to the study of anatomy, physiology, and pathology of a given subject. This work is under the direction of a member of the division of anatomy, physiology, or pathology. A review is made of the structures and functions of organs whose diseases are to be discussed by clinicians on the following day. During the Saturday meetings patients who have been referred to the diagnostic clinic of the University of California Medical School from the district are presented to the group of local physicians for further study and discussion.

In charge of these sessions are members of the clinical teaching staff of the Medical School and other guest clinicians, drawn from other medical schools or from among other members of the California Medical Association; when possible, an eminent physician visiting from outside the State will be invited to guide the session. In each district there is a local committee organized, whose chairman is in close contact with the Medical School. It is this committee which collaborates in arranging sessions, in organizing programs, and in teaching.

These conferences are open to all regularly licensed physicians of the State.

It is hoped that by the development of this teaching program that the powers of the medical profession to deal effectively with the prevention and cure of disease may be greatly increased.

Yours truly,

LANGLEY PORTER, M.D.,
Dean of the University of California Medical School, San Francisco.

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ECONOMIC SECURITY

This is a statement of events for informative purposes.

During the late summer President Roosevelt appointed a Cabinet Committee on Economic Security, composed of Secretary of Labor Frances Perkins, Harry L. Hopkins, Secretary of the Treasury Morganthau, Attorney-General Cummings, and Secretary of Agriculture Wallace.

The Cabinet Committee appointed a medical advisory subcommittee of eleven members. In selecting the appointees no recognition was given to any medical organization. The following were appointed: Drs. Harvey Cushman, Stuart R. Roberts, George W. Crile, Thomas Parrau, Jr., James D. Bruce, Rexwald Brown, James A. Miller, Walter I. Bierring, George M. Piersol, Robert B. Greenough, and J. Shelton Horsley.

A technical committee for the above committee was appointed, to be constituted by the following: Michael Davis, I. S. Falk, Edgar Sydenstricker, and Nathan Sinai. Later Doctor Leland and Mr. Simmons of the American Medical Association Bureau of Economics were added to the technical committee.

The above committee met in Washington in November and held a round-table discussion. The committee asked for further time for study and adjourned to meet early in January. The impression has been given out that no immediate action will be taken relative to health insurance, but that in the next four months a trend would be visioned.

Some reports are to the effect that no health insurance plan will be advanced at this time and that the President is opposed to any plan that will require the expenditure of large sums of federal money.

The American Association for Labor Legislation has sent out a letter asking that telegrams and letters be sent to Secretary Perkins urging immediate action on the subject of health insurance. The weekly radio broadcast on "Dollars, Doctors, and Disease" is said to be sponsored by proponents for health insurance. The same is said to be true in regard to literature that is being sent out on this subject urging legislation.

The California Senate's Interim Committee held a two-day hearing in San Francisco on December 14 and 15. The Senate Committee met with the Council of our Association on December 23.

The Journal of the American Medical Association has been reporting developments as they become known.

COUNCIL MINUTES

Minutes of the Two Hundred and Twenty-Ninth Meeting of the Council of the California Medical Association

The following minutes were approved by the Council at its adjourned two hundred and twenty-ninth meeting, held at San Francisco, Saturday, December 22, 1934.

Held in the Sunset Room, California Club, 538 South Flower Street, Los Angeles, California, Saturday, October 6, 1934, at 9 a. m.

Present.—Doctors Clarence G. Toland, president; Edward M. Pallette, speaker; T. Henshaw Kelly, chairman of the Council; Karl L. Schaupp, chairman of the Executive Committee; Councilors W. W. Roblee, C. O. Tanner, Carl R. Howson, H. J. Ullmann, Henry S. Rogers, O. D. Hamlin, M. R. Gibbons, J. B. Harris, Harry H. Wilson, and W. H. Kiger; Editor George H. Kress; Secretary F. C. Warnshuis, and General Counsel Hartley F. Peart.

Absent.—Councilors Fred R. DeLappe, C. E. Schoff, and Alfred L. Phillips; and chairman of the Committee on Public Relations, Charles A. Dukes.

1. **Call to Order.**—The meeting was called to order by the chairman, T. Henshaw Kelly.

2. **Administration of Anesthetics.**—The chairman stated that, with the consent of the Council, the printed order of business would be suspended and that the privilege of the floor would be granted F. V. Chalmers-Francis that he might discuss the present status of the case of Chalmers-Francis vs. Nelson.

Doctor Chalmers-Francis stated that he had been selected by the Anesthesia Section of the Los Angeles County Medical Association to act on its behalf in testing the legality of administration of anesthetics by nurses. Doctor Chalmers-Francis stated that Superior Judge Roth of Los Angeles ruled that a medical license was a property right and an injunction was granted, that a demurrer was filed and overruled and an answer filed. The action was tried before Judge Allen Campbell of Bakersfield, who ruled that the administration of anesthetics by a nurse under the direct supervision of a surgeon was not a violation of the Medical Practice Act. A motion for a new trial is set for hearing on October 13, 1934, and if motion is denied, notice of appeal will be filed.

Doctor Chalmers-Francis outlined the expenses already incurred and the amount necessary to carry on the case, and asked for financial assistance from the Association.

At this point Dr. William C. Woodward of the Bureau of Legal Medicine and Legislation of the American Medical Association was presented to the Council and discussed the problem briefly.

Action by the Council.—On motion of Ullmann, seconded by Harris, and unanimously carried, the following resolution was adopted:

Resolved, That a committee of five be appointed by the chairman of the Council, consisting of the chairman of the Council, the General Counsel, and three other members, to consider the matter of procedure in the case of Chalmers-Francis vs. Nelson, with full

power to act and with authority to expend not to exceed $1,500.

The chairman appointed Doctors Kelly, Toland, Roblee, Warnshuis, and Mr. Peart as members of the committee.

3. **Committee of Five.** — Professor Paul A. Dodd, Director of Survey, and Gordon S. Watkins, Supervising Economist, were presented to the Council. Doctor Dodd outlined the work done by the committee and stated that, through the coöperation of the State Board of Health, $50,000 had been secured from the Federal Government to aid in the study and that the actual field work was now started in two counties and that within two weeks would be extended to twenty-three other counties, containing 92 per cent of the population of the State. Doctor Dodd stated that the field work would be under the auspices of the California Board of Health, but the survey of hospital and members of the Association would be under the California Medical Association, and that the questionnaires sent to individuals would be the property of the Government.

Doctors Wilson and Schaupp then spoke of the work of the committee.

Action by the Council.—On motion of Ullmann, seconded by Schaupp and unanimously carried, the following resolution was adopted:

Resolved, That the report of the committee be accepted and that the activities of the committee thus far taken be approved.

4. **Minutes.**—The minutes of the two hundred and twenty-eighth meeting of the Council, as mailed to all members, were submitted for approval.

Action by the Council.—On motion of Ullmann, seconded by Hamlin and unanimously carried, the following resolution was adopted:

Resolved, That the minutes of the two hundred and twenty-eighth meeting of the Council be approved.

The minutes of the one hundred and forty-first meeting of the Executive Committee were presented.

Action by the Council.—On motion of Pallette, seconded by Tanner and unanimously carried, the following resolution was adopted:

Resolved, That the minutes of the one hundred and forty-first meeting of the Executive Committee be approved.

5. **Financial Statements.** — Financial statements for the months of June, July, and August, 1934, were presented by the secretary and were approved as presented.

6. **Membership.**—The secretary stated that the total paid membership as of October 3, 1934, was 4,854; that 646 members had paid their dues since April 1; that 360 members were at present delinquent, made up as follows: Los Angeles, 226; San Francisco, 35; San Diego, 27; and thirty-six small counties, 72.

The secretary stated that in accordance with Chapter II, Section 2 (b) of the by-laws, members whose dues had been received since April 1, 1934, should be reinstated to membership in the Association.

Action by the Council.—On motion of Ullmann, seconded by Gibbons and unanimously carried, the following resolution was adopted:

Resolved, That all members of the California Medical Association who have been reinstated by component county medical societies since April 1, 1934, be reinstated to good standing in the California Medical Association.

Membership data and request from the San Diego County Medical Society that George B. Worthington be recommended for affiliate fellowship in the American Medical Association was presented.

Action by the Council.—On motion of Gibbons, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That the Council of the California Medical Association recommend that George B. Worthington be granted affiliate fellowship in the American Medical Association.

7. **Resolutions.** — Discussion was had of the procedure in presentation of resolutions to the House of Delegates and the duties and powers of the Reference Committees.

Action by the Council.—On motion of Kress, seconded by Roblee, and unanimously carried, the following resolution was adopted:

Resolved, That the chairman of the Council appoint a committee of three with instructions to prepare rules for the guidance of the two Reference Committees of the House of Delegates, and that the committee report at the January meeting of the Council.

The chairman appointed Doctors Pallette, Toland, and Kelly as members constituting this committee.

The secretary was instructed to reply to the letter of the Pacific Roentgen Club advising of the action taken by the Council.

8. **Ross-Loos Appeal.**—Edward M. Pallette, referee appointed for the purpose of taking evidence upon all points and questions involved in the appeal of Doctors Ross and Loos and who had been authorized to employ a competent court reporter for the purpose of taking the depositions and statements of all witnesses who might be produced by the appellants and respondents, submitted his report.

9. **Legislation.**—Correspondence from a Los Angeles County Society member concerning the medical viewpoints of one of the candidates in the present gubernatorial campaign was presented.

Action by the Council.—On motion of Pallette, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That inasmuch as it has always been the policy of California and Western Medicine to withhold publication of matters of a political nature, the action of the editor in not publishing the correspondence, be approved by the Council and the communication be filed.

Discussion was had of pending legislation of interest to the profession.

Action by the Council.—On motion of Ullmann, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That the chairman of the Committee on Public Policy and Legislation, the chairman of the Council and the secretary be authorized to inform the members of the medical profession and its friends regarding pending legislation and to expend the necessary funds therefor.

Doctor Harris, chairman of the Legislative Committee, then submitted a report on legislation.

Mr. Peart recommended that he be instructed to present to the Executive Committee for approval the California Medical Association's County Hospital Bill of 1933 and make arrangements for its presentation to the legislature; and amendments be prepared to the insurance code on health and accident insurance to cover hospital insurance only and to exclude x-ray, pathology, and every other form of medical service; that amendments to the Medical Practice Act be prepared in reference to corporate practice; and possibly the Basic Science Act be considered.

Dr. George H. Kress, chairman of the Committee on the Basic Science Act, presented a report for his committee in the form of a "Qualifying Certificate Law," commenting on the major features in the draft, copies of which had been sent to the councilors.

Action by the Council.—On motion of Kress, seconded by Kiger and unanimously carried, the following resolution was adopted:

Resolved, That the Special Committee on the Basic Science Act be instructed to further consider the Qualification Certificate Act, which had been drafted into better form, the same to be then submitted for the Council's consideration.

10. **Ross-Loos Appeal.** — The hour of 11:30, which was set for the hearing of the appeal of Doctors H. Clifford Loos and Donald Ross, having arrived, the Council convened to continue the hearing of the appeal. Doctors H. Clifford Loos and Donald Ross thereupon appeared with their counsel, Messrs. Wright and Farrer of Hill, Morgan and Bledsoe of Los Angeles. Dr. Philip Stephens, president, and Dr. Harry H. Wilson, secretary, appeared for the Los Angeles County Medical Association, with Oscar R. Cummins, Esq., counsel for the said association. Reading of the

transcript of testimony given before the special commission then began.

11. **Recess of the Council.**—At the hour of 12:30 p. m. a recess of the Council was called for luncheon.

12. **Call to Order.**—The Council was called to order at the hour of 1:45 p. m. to continue the reading of the transcript of testimony in the Ross-Loos appeal. Doctors H. Clifford Loos and Donald Ross thereupon appeared with their counsel, Messrs. Wright and Farrer of Hill, Morgan and Bledsoe of Los Angeles. Doctor Philip Stephens, president, and Dr. Harry H. Wilson, secretary, appeared for the Los Angeles County Medical Association, with Oscar R. Cummins, Esq., counsel for the said association. Reading of the transcript of testimony given before the special commission was then continued. The court reporter's transcript of the proceedings on this appeal is affixed hereto as part of the minutes.

At 4 p. m. the hearing by stipulation of all interested parties was adjourned to 9:30 October 14, 1934, in the offices of the Association, Suite 2004, 450 Sutter Street, San Francisco.

13. **Malpractice Insurance.** — The general counsel explained the present status of malpractice insurance.

Action by the Council.—On motion of Kress, seconded by Rogers and unanimously carried, the following resolution was adopted:

Resolved, That a committee be appointed consisting of the president, the speaker of the House, the chairman of the Council, the chairman of the Executive Committee, and the chairman of the Committee on Medical Defense and the general counsel, to study the problem of malpractice insurance and report to the Council.

14. **County Hospitals.**—The general counsel reported on the case of Goodall vs. Brite. No action taken.

15. **Disciplinary Procedure.** — The general counsel stated that he had prepared a form of procedure for use in disciplining members. He stated that all societies should be advised on this point.

Action by the Council.—On motion of Ullmann, seconded by Gibbons and unanimously carried, the following resolution was adopted:

Resolved, That the secretary extract the procedure on discipline as prepared by the general counsel and the provisions of the Constitution and By-Laws of the San Francisco County Society on the subject and send them to the secretary of each county society for possible adoption by the society.

16. **Copyright for Journal.**—The editor brought the value of copyrighting each issue of the JOURNAL to the attention of the Council.

Action by the Council.—On motion of Kress, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the secretary or the editor be empowered to secure a copyright for each issue of the JOURNAL.

17. **Advertising Contract.**—Letter from Mr. Adam Guttman asking that his contract be continued and that he be allowed a further drawing account, was presented.

Action by the Council.—On motion of Pallette, seconded by Hamlin and unanimously carried, the following resolution was adopted:

Resolved, That the advertising contract with Mr. Guttman be continued on a strictly percentage basis until terminated.

18. **Professional Cards.** — The question of professional cards in the JOURNAL was brought up and it was pointed out that, by previous ruling of the Council, publication of such cards was discontinued.

It was stated that the matter of hospital advertisements carrying the names of staff members should be discussed at the next meeting of the Council.

19. **Advertising in Journal.**—Discussion was had of a prospective advertisement by a collection agency in the JOURNAL, and on motion of Kress, seconded by Harris and unanimously carried, the following resolution was adopted:

Resolved, That the matter be referred to the secretary for further investigation.

20. **Pan-American Cruise.**—Correspondence regarding the Pan-American cruise was presented.

Action by the Council.—On motion of Schaupp, seconded by Gibbons and unanimously carried, the following resolution was adopted:

Resolved, That the former action of the Council to not publish the article be sustained.

21. **Interstate Postgraduate Medical Association.**—A letter from the Committee on Publications regarding publicity in CALIFORNIA AND WESTERN MEDICINE was presented.

Action by the Council.—On motion duly made, seconded and unanimously carried, the following resolution was adopted:

Resolved, That the action of the Committee on Publications to not give publicity be sustained.

22. **Articles for Journal.**—An article submitted for publication in the JOURNAL by a member of the Los Angeles County Medical Association was presented and the action of the Committee on Publications recommending that it be not published was upheld.

An article by a member of the San Francisco County Medical Society was presented, and it was stated that a similar article had been published in the *Journal of Surgery, Gynecology and Obstetrics* by the same author and that the ruling that only original articles be published in the JOURNAL precluded publication thereof.

23. **Unkeyed Bibliographies.**—The question of unkeyed bibliographies in the JOURNAL was discussed.

Action by the Council.—On motion of Schaupp, seconded by Tanner and unanimously carried, the following resolution was adopted:

Resolved, That the action of the editor in withholding publication of unkeyed bibliographies be sustained.

24. **San Diego County Society Community Medical Service Plan.**—Dr. C. O. Tanner reported on the proposed Community Service Plan of the San Diego Society.

The general counsel then discussed the plan in relation to the insurance laws of California and the Medical Practice Act.

It was called to the attention of the Council that any county medical society or group of its members who desire to obtain the approval of the Council for the establishment of a medical service or hospital service plan must first obtain the endorsement of the members of the local society by a two-thirds majority vote. It was stated that since this provision had not been complied with, the Council could not take definite action on the plan.

The general counsel stated that he would send suggestions to the San Diego County Society so that the plan may be made to comply with California law.

25. **Funds of Association.**—The secretary presented a report on the transfer of funds of the Association into the custody of the new secretary as of September 29, 1934.

26. **Placement Bureau Service.** — The secretary explained the present system of handling the Placement Bureau in the State office.

Action by the Council.—On motion of Kress, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be authorized to initiate a column in the JOURNAL for non-medical applicants of the Placement Bureau and that an advertising charge of one dollar be made for one twenty-five-word insertion.

27. **Adjournment.**—The Council then adjourned until Sunday, October 14, 1934, at 9:30 a. m. at the office of the Association.

T. HENSHAW KELLY, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

N. B.—Copy of the court reporter's transcript referred to in item No. 12 is on file in the office of the Association for reference by councilors and officers.

Minutes of the Adjourned Two Hundred and Twenty-Ninth Meeting of the Council of the California Medical Association

Held in the offices of the California Medical Association, Sunday, October 14, 1934, at 9:30 a. m.

Present.—Doctors Clarence G. Toland, president; Edward M. Pallette, speaker; T. Henshaw Kelly, chairman of the Council; Karl L. Schaupp, chairman of the Executive Committee; Councilors W. W. Roblee, Carl R. Howson, Henry J. Ullmann, Fred R. DeLappe, Alfred L. Phillips, Henry S. Rogers, Harry H. Wilson, C. O. Tanner, W. H. Kiger, Morton R. Gibbons, J. B. Harris; F. C. Warnshuis, secretary; and General Counsel Hartley F. Peart.

Absent. — Doctors C. E. Schoff, O. D. Hamlin, Robert A. Peers, C. A. Dukes and George H. Kress, editor.

1. **Ross-Loos Appeal.**—The chairman called the adjourned meeting of the Council to order at 9:30 a. m. He stated that, in accordance with the stipulation of the parties at the last meeting of the Council, the reading of the transcript of testimony in the matter of the Ross-Loos appeal would be continued. Mr. Cummins then continued the reading of the transcript from page 176, line 11. At 12:30 p. m. the reading of the transcript was completed and a recess of the Council was taken for luncheon, it having been agreed that the Council would reconvene after the recess at 1:30 and that arguments of counsel would be heard from 1:30 to 5:30. At 1:30 the Council was called to order and counsel for the appellants and respondent argued the appeal before the Council. Attorney Kenneth K. Wright opened, Attorney Oscar Cummins replied, and Attorney Wright closed, at 5:30 o'clock p. m. It was stipulated at the close of the arguments that a brief of the arguments would be submitted in writing by the appellants, and a reply submitted by the respondent, and a closing brief by the appellants, and that copies of these briefs would be furnished to each councilor, and that after this had been done a date would be set for the continuance of the adjourned meeting and further deliberations.

2. **Administration of Anesthetics.** — The secretary stated that, in accordance with Council action, the chairman had appointed as members of the Committee on Nurse Anesthetists, T. Henshaw Kelly, C. G. Toland, W. W. Roblee, F. C. Warnshuis, and Hartley F. Peart. Doctor Kelly stated that the committee had met and, after investigation and discussion of the whole matter, recommended the adoption of the following resolution:

Whereas, Dr. William V. Chalmers-Francis and other representatives of the Anesthesia Section of the Los Angeles County Medical Association commenced an action in the Superior Court of Los Angeles County, numbered 364130 on the records thereof, against Dagmar M. Nelson and St. Vincent's Hospital, to restrain and enjoin the defendant, Dagmar M. Nelson, from administering anesthetics without being licensed as a physician and surgeon under the State Medical Practice Act, and the said St. Vincent's Hospital from permitting said Dagmar M. Nelson to so administer anesthetics in its hospital, and to determine if possible that the administration of anesthetics constitutes the practice of medicine; and

Whereas, Said Superior Court has determined said action adversely to the contentions of the plaintiffs; and

Whereas, Although neither the officers nor the Council of the California Medical Association were advised of the commencement of the said action until said adverse judgment had been rendered, the issues involved therein affect the entire membership of the Association; and

Whereas, The general counsel of this Association reports that his services on said appeal, if rendered in conjunction with Mr. LeRoy Anderson, the attorney for the plaintiffs, who tried the case, will not exceed in amount the sum of $750; now therefore be it

Resolved by the Council, That the sum of $750 be appropriated to defray in part the cost of printing transcript and briefs on appeal, and that the general counsel of this Association be and he is hereby authorized and directed to assist in the taking and prosecuting of an appeal from the said judgment; provided that the balance of the funds necessary to obtain such transcript and to print the necessary briefs are available to the satisfaction of the chairman of the Council and the secretary, and provided further that the general counsel of this Association is given the authority to approve the procedure and briefs on said appeal by said plaintiffs and their counsel.

Action by the Council.—On motion duly made, seconded and carried, the foregoing resolution was unanimously adopted by the Council.

3. **Committee on Resolutions Presented to the House of Delegates.**—The secretary reported that, in accordance with Council action, the chairman had appointed as members of the Committee on Rules and Procedures in Presentation of Resolutions to the House of Delegates, President Clarence G. Toland, Speaker Edward M. Pallette (chairman), and chairman of the Council, T. Henshaw Kelly.

Doctor Pallette then submitted a draft of the rules, which was discussed.

Action by the Council.—On motion of Pallette, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That the rules be approved and the secretary be instructed to publish them in California and Western Medicine and also to incorporate them in the pre-convention handbook, and the chairman of the Council be instructed to include them in the report of the Council to the House of Delegates and to introduce them as a resolution for adoption by the House of Delegates at its 1935 annual session.

"Instructions to Reference Committees and Rules Governing Introduction of Resolutions and Reports in the House of Delegates

Enactment.—The house of Delegates creates the following procedure and rules governing the introduction of resolutions and reports of officers and committees and their consideration by the Reference Committees of the House of Delegates.

Introduction of Resolutions:

1. All resolutions introduced in the House of Delegates *must* be presented in triplicate and signed.

2. Delegates contemplating the introduction of resolutions will expedite the deliberations if such resolutions are sent to the Association's secretary thirty (30) days before the House convenes. They will be printed in the Pre-Convention Bulletin for the advance information of delegates.

3. In presenting a resolution the delegate shall not engage in any introductory comment or argument. He shall read only the context of the resolution. The Speaker will then refer it to the proper Reference Committee, if the resolution is in order, and the secretary shall make every possible effort to place copies of the resolution in the hands of each member of the House of Delegates before the next meeting of the House.

4. The introducer and any delegate interested in a resolution should appear before the Reference Committee to present facts and arguments. Further discussion is then to be deferred until the Reference Committee submits its report and recommendations to the House of Delegates.

Reference Committee Procedures:

1. Reference Committee chairmen will be given a portfolio containing a copy of all resolutions, reports or matters referred to their committees at the close of each session of the House of Delegates.

2. Reference Committee chairmen, before the adjournment of each session of the House of Delegates, shall announce the time and place of the meeting of their committees.

3. Delegates are requested to advise Reference Committee chairmen of their desire to appear before a committee and obtain an appointment.

4. Reference committees will review and consider each resolution, report on all matters referred to the

committees, and may approve, disapprove or amend any offered resolution or offer a substitute resolution for it.

5. The speaker, councilors, and secretary shall be available for consultation and advice, and Reference Committees should avail themselves of their services.

6. At the conclusion of a hearing and the consideration of resolutions or questions, the Reference Committees shall observe the following procedure when reporting to the House of Delegates:

(*a*) The reports of the Reference Committees shall be in writing and signed by all the Reference Committee members present and acting. The original resolutions and questions shall be set forth in the report in their proper places.

(*b*) The committee shall briefly summarize their findings and comments on each resolution or question.

(*c*) The committee shall recommend the following action: (1) That the resolution be adopted. (2) That the resolution be not adopted. (3) That an amended or redrafted resolution offered by the Reference Committee be considered and adopted as a substitute for the original resolution.

7. The Reference Committee to whom reports of officers and standing or special committees are referred shall submit a written report signed by all the members present and acting of the committee. The following findings and comments shall be set forth in its report to the House of Delegates.

(*a*) A brief summary and comment emphasizing the outstanding features of the address or report.

(*b*) Explanation as to what the Standing Committee's recommendation entails.

(*c*) Recommending the action to be taken, namely, to approve, adopt or disapprove or amend.

8. Delegates may then make such motions or arguments, and the House of Delegates may take such action as is permitted by parliamentary rules and the Constitution and By-Laws.

9. The Council of the California Medical Association recommends that the House of Delegates adopt these governing procedures and rules."

4. **Invited Guests.**—A letter was read by the secretary embodying the recommendations of the Committee on Scientific Work that official invitations to speak before the next annual session be extended to E. Starr Judd, M.D., Mayo Clinic, Rochester, Minnesota; James S. McLester, M.D., president-elect of the American Medical Association, Birmingham, Alabama; Thomas Sprunt, M.D., Johns Hopkins Medical School, Baltimore; and George Whipple, M.D., Medical Department, University of Rochester, New York.

Action by the Council.—On motion of Gibbons, seconded by Howson and unanimously carried, the following resolution was adopted:

Resolved, That the recommendations of the Committee on Scientific Work be approved and invitations be extended to E. Starr Judd, James S. McLester, Thomas Sprunt, and George Whipple to address the California Medical Association at its next annual session at Yosemite.

5. **Extension Lecture Program.**—The matter of discussion of Extension Lecture Program was referred to the next meeting of the Council.

6. **Legislation.** — Discussion was had of pending legislation of interest to the medical profession.

7. **Advertisement for the Journal.**—Final discussion was had of an advertisement submitted for publication in the JOURNAL and discussed at the meeting of the Council on October 6, 1934. After thorough consideration it was decided that the advertisement be not accepted.

8. **Medical Economics.**—The question of debates by school children on topics of medical economics was discussed. It was pointed out that the problem was too profound for debaters of school age.

Action by the Council.—On motion of Toland, seconded by Gibbons and unanimously carried, the following resolution was adopted:

Resolved, That the Council of the California Medical Association disapproves debates on questions of medical economics by High School pupils for the reason that the debaters are unable to present complete and exhaustive arguments on the topics, and both the children and the audiences thereby obtain misleading information and a misconception of the entire question.

9. **Adjournment.**—At this point the meeting adjourned to reconvene at the call of the chairman.

T. HENSHAW KELLY, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

Minutes of the Adjourned Two Hundred and Twenty-Ninth Meeting of the Council of the California Medical Association

Held in the auditorium of the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles, California, Saturday, November 10, 1934, at 10 a. m.

Present.—Doctors C. G. Toland, president; R. A. Peers, president-elect; E. M. Pallette, speaker; T. Henshaw Kelly, chairman of the Council; K. L. Schaupp, chairman Executive Committee; W. W. Roblee, C. R. Howson, H. J. Ullmann, F. R. DeLappe, A. L. Phillips, H. S. Rogers, H. H. Wilson, C. O. Tanner, W. H. Kiger, M. R. Gibbons, J. B. Harris; Charles A. Dukes, chairman of Committee on Public Relations; F. C. Warnshuis, secretary; George H. Kress, editor; Hartley P. Peart, general counsel.

Absent.—Doctors Hamlin and Schoff.

1. **Call to Order.**—The two hundred and twenty-ninth adjourned meeting of the Council was called to order by the chairman, T. Henshaw Kelly.

2. **Initiatives No. 9 and No. 17.**—The secretary presented the report of the Special Committee appointed by the Council on the Chiropractic and Naturopathic initiatives, as follows:

"Your Special Committee, charged with the duty of mobilizing the Association's resources to secure the defeat of State Initiatives No. 9 (Chiropractic) and No. 17 (Naturopathic), respectfully submits this as its report.

"The following literature was prepared and distributed:

72,000	letters to physicians and dentists (three separate mailings).
500	letters and posters to hospitals and institutions.
15,000	reception room placards.
2,000,000	voters' cards.
2,000,000	voters' leaflets.
1,000,000	newspaper articles.
290,000	post cards.
50,000	informative facts.
5,387,500	total pieces of literature provided.

"With the splendid aid of the Public Health League of California all this literature, except the letters, was distributed to physicians, dentists, and League units for redistribution to the public.

"Your Committee wishes to record its recognition of the splendid field work done by our members and for the whole-hearted coöperation evidenced by our county units. Many county societies contributed additional literature and funds for their respective counties and conducted most effective campaigns.

"Appreciation is also expressed to members of the dental profession for their loyal and active support.

"The Public Health League of California exhibited anew its educational resources and strength, and its officers and members merit our hearty thanks, which is hereby tendered.

"Your committee desires to direct attention to the demonstration that was evidenced by this campaign. It reiterates most forcefully that unity of action brings results. Similar united action and effort will enable us to satisfactorily solve and direct all our economic problems and public relations.

"Radio: After consideration, your committee determined to also utilize the radio to impart public information. It is impossible to estimate the results obtained from this feature of the campaign. The committee desires to express its thanks to the speakers who spoke on the radio program.

"Your committee reports the expenditure of the following funds:

October 8—		
Barry Company:		
Postage on circulars, etc.		$ 509.50
October 20—		
Barry Company, printing:		
15,500 circular letters, two folds	$ 93.00	
30,000 special green envelopes, No. 10	120.00	
20,000 twelve-page pamphlets (informative facts)	220.00	
500 letters to hospital superintendents	7.50	
500 letters to staff members	10.00	
State sales tax	11.75	
		462.25
October 26—		
Special legislative expenses		100.00
Don Lee Radio Station KFRC		3,115.00
Radio		2,365.00
Paid		$ 6,551.75
October 28—		
Barry Company:		
Postage on circulars, etc.	$ 617.17	
		617.17
October 20—		
Barry Company, printing:		
20,000 wall cards, punched, 9 and 17	$ 175.00	
12,000 circular letters, "Voters of California"	70.00	
Sales tax	6.12	
		251.12
October 25—		
Barry Company, printing:		
1,000,000 election cards, two sides	$ 600.00	
1,000,000 leaflets	1,750.00	
12,000 circular letters	65.00	
6,000 special manufacturing green envelopes	36.00	
State sales tax	61.28	
		2,512.28
October 31—		
Barry Company, printing:		
1,000,000 folders	$1,691.25	
1,000,000 election cards	563.73	
1,000,000 reprints	922.50	
5,500 Columbia clasp envelopes and printing	75.10	
5,500 instructions to doctors	20.50	
285,000 post cards	439.18	
Freight literature to Los Angeles	71.47	
Barry Company printing, seal, folding	425.00	
Barry Company paid express charges	130.03	
Telegrams	16.18	
		4,354.94
		$14,288.26

"Approval of these expenditures is requested.

Submitted,

T. Henshaw Kelly
J. B. Harris
F. C. Warnshuis."
Council's Committee.

3. **Financial Statement.** — Financial statements for the months of September and October, 1934, were presented by the secretary and approved by the Council.

4. **Bond for Cashier.**—The secretary reported that at present a bond was being carried for the cashier and that at no time was she in charge of funds in excess of $50, and the bonding was, therefore, a needless expense.

Action by the Council.—On motion of Schaupp, seconded by Phillips and unanimously carried, the following resolution was adopted:

Resolved, That the bond upon L. T. Bradford, cashier, be not renewed.

5. **Membership Certificate.**—The secretary presented a Certificate of Membership and stated that he would suggest the use of such certificate by the Association henceforth in place of the pocket membership card.

Action by the Council.—On motion of Kress, seconded by Phillips and unanimously carried, the following resolution was adopted:

Resolved, That a membership certificate be adopted in lieu of the pocket membership card and that in the coming year the certificate be sent to each member.

6. **Annual Session.**—The secretary stated that invitations had been extended to and acceptances received from E. Starr Judd, Mayo Clinic; James S. McLester, president-elect of the American Medical Association, Birmingham, Alabama; Thomas P. Sprunt, Johns Hopkins Medical School, Baltimore; and G. H. Whipple, Rochester, New York. The secretary brought to the attention of the Council the desirability of devoting one general session to the discussion of medical economics by outstanding California speakers.

Action by the Council.—On motion of Dukes, seconded by Rogers and unanimously carried, the following resolution was adopted:

Resolved, That the suggestion of the secretary that one general session be devoted to discussion of medical economics be approved.

7. **Physical Therapy.**—The secretary read a letter from the chairman of the Committee on Physical Therapy suggesting that the Association defray part of the expense of guest speakers for a seminar on physical therapy.

Action by the Council.—On motion of Ullmann, seconded by Kiger and unanimously carried, the following resolution was adopted:

Resolved, That the California Medical Association, because of the expense involved and the danger of establishing a precedent, considers it inadvisable at this time to contribute toward any courses in special branches of medicine.

8. **Death of Percy Todd Phillips.** — T. Henshaw Kelly, chairman of the Council, presented the following resolution on the death of Dr. Percy Todd Phillips:

"Percy Todd Phillips died at his home in Santa Cruz after a long illness on November 29, 1934.

"He had lived and practiced in Santa Cruz for thirty years, and in that time devoted himself to the welfare and health of the people of his community and to the affairs of his profession through his untiring efforts in the California Medical Association and as a member and president of the California State Board of Medical Examiners.

"He was made president-elect of the California Medical Association at Oakland in 1926, and president in 1927.

"In all of his offices in the Association he was indefatigable in seeking the good of the Association and the betterment of medicine and the physician in California, and his service on the Board of Medical Examiners was marked by the same ability, judgment and sense of responsibility that we in the California Medical Association had found to be characteristic of him.

"His family, all of his patients and many other people of his neighborhood and the California Medical Association will miss him and his kindness, capability, and conscientious devotion to his chosen work.

"Therefore Be It Resolved, That the Council of the California Medical Association express its sorrow at his death and its consciousness of the loss that organized medicine has suffered and direct that this resolution be spread upon the minutes and a copy sent to his family."

The foregoing resolution was unanimously adopted and the Council rose in honor of the memory of Doctor Phillips.

9. **Annual Conference of Secretaries.**—The secretary presented the following report on the annual conference of secretaries:

"It has been found that calling the secretaries of county societies into annual conference is productive of very desirable benefits. It is well recognized that the achievements and activities of a county unit are dependent in a great measure upon the initiative and activity of the county secretary. A county secretary cannot reflect the desired executive and administrative acumen unless he is intimately informed upon policies, Council and committee activities of the State Association and transmit them to the members.

"The annual meeting does not afford the time for a full presentation and discussion of our Association's objectives and work.

"Your secretary respectfully recommends that the Council authorize:

"1. The calling and conducting of an all-day conference of county secretaries on the day preceding or succeeding the January Council meeting.

"2. The travel expenses of county secretaries and a dinner to be paid by the Association.

"3. That the arrangement for a program be delegated to the president, chairman of the Council, president-elect, and the secretary.

"4. That such conference be held annually."

The secretary then presented a suggested program for the conference.

Action by the Council.—On motion of Ullmann, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That an annual conference of county society secretaries be held and that the traveling expenses of secretaries and the cost of a dinner be paid by the Association.

10. **Charters.**—Discussion was had of the provisions for county hospitals in county charters. The general counsel suggested that the secretary, the chairman of the Council, and the counsel be instructed to prepare an outline of the provisions governing county hospitals which they considered desirable for inclusion in county charters.

Action by the Council.—On motion of Peers, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That the suggestions of the general counsel be approved.

11. **Lay Anesthetists.**—The general counsel reported on the status of the case of Chalmers-Francis vs. Nelson.

12. **Corporate Practice.** — The general counsel reported on the case of the Pacific Employers' Insurance Company vs. Mitchell, Insurance Commissioner. Mr. Peart stated that the Pacific Employers' Insurance Company were endeavoring to compel the insurance commissioner to approve two forms of policies to cover medical, hospital, and dental care; that the application for a writ of mandate would come up for hearing on November 13 and that it had been suggested that the counsel for the Association appear on behalf of the physicians as *amicus curiæ* on the proceeding.

Action by the Council.—On motion of Ullmann, seconded by Gibbons and unanimously carried, the following resolution was adopted:

Resolved, That the general counsel be authorized to appear as *amicus curiæ* on behalf of the California Medical Association in the proceeding for the writ of mandate brought by Pacific Employers' Insurance Company vs. Mitchell, Insurance Commissioner.

13. **Animal Experimentation Exhibit.** — The secretary stated that he had secured Doctor Ivy's exhibit on "Contributions of Animals to Human Health" for exhibition at Sacramento during the legislative session. Doctor Harris stated that he would arrange the display of the exhibit at Sacramento.

The question of reprints of Doctor Ivy's article was then discussed.

Action by the Council.—On motion of Kress, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the secretary order ten thousand reprints of two California and Western Medicine articles by Professor Ivy and the article by Chester Rowell, Esq., the same to be printed in a single booklet.

14. **San Bernardino County Society.**—Doctor Toland asked that the privilege of the floor be granted Dr. P. M. Savage of San Bernardino, which request was granted by the Council.

Doctor Savage then explained the difficulties that had arisen in San Bernardino County in the care of individuals under the State Emergency Relief Program.

Action by the Council.—On motion of Peers, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That President Toland, Councilors Harry H. Wilson and William W. Roblee, and Secretary Warnshuis be requested to attend the meeting of the San Bernardino County Society on Tuesday evening, November 13, 1934.

15. **Governor's Committee of Eleven.** — Discussion was had of the committee to be appointed by the Governor to handle the moneys from the State bond issue for relief and unemployment.

Action by the Council.—On motion of Pallette, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be instructed to write the Governor that it is the sense of the Council that one member of this committee be appointed from the membership of the California Medical Association.

16. **Woman's Auxiliary.** — A letter was presented from the Woman's Auxiliary asking that they be given additional space in California and Western Medicine because of increase in activities and the number of component auxiliaries.

Action by the Council.—On motion of Kress, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the Woman's Auxiliary be allowed two pages in the Journal.

17. **Committee of Five.**—The attention of the Council was called to the fact that through the facilities of the State Board of Health more than $50,000 had been obtained from the Federal Government for a field survey of sickness incidence in California and that the report would be of assistance in the medical economics survey.

The secretary of the Committee of Five stated that Doctor Dodd had asked for an additional allocation of funds in the amount of $3,819.54 over and above the $14,000 previously authorized. The necessity for this additional expenditure was explained as due to the refusal of the SERA to pay any supervisorial costs.

Action by the Council.—On motion of Schaupp, seconded by Kress and unanimously carried, the following resolution was adopted:

Resolved, That an additional $5,000 be appropriated for the Committee of Five, to be disbursed by regular voucher check.

18. **Lien Law.**—Discussion was had of a proposed lien law in automobile accidents.

Action by the Council.—On motion of Wilson, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That the proposed lien law be referred to the Legislative Committee.

19. **Medical Practice Act.**—Doctor Kress brought up the desirability of amending the Medical Practice Act to prohibit advertising making special reference to fee schedules.

Action by the Council.—On motion of Kress, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That the Council approve in principle an amendment to the Medical Practice Act providing for additional safeguards to prevent unethical advertising; and that the Committee on Legislation be empowered to consult other interested State boards and enlist coöperative action to such end.

20. **Qualifying Certificate Act.**—Doctor Kress, as chairman of the Special Committee on the Qualifying Certificate Act, stated that he felt that thought should be given to the enactment of a Qualifying Certificate Act for the State of California, preferably in the form of an initiative law which could be submitted to the voters at the next regular State election in 1936, or perhaps previously, in case a special State election be held before 1936.

Action by the Council.—On motion of Kress, seconded by Toland and unanimously carried, the following resolution was adopted:

Resolved, That the Special Committee on a Qualifying Certificate (Basic Science Act) be instructed to send copies of its revised draft of a Qualifying Certificate Act (as outlined in the November California and Western Medicine) to all members of the Council and to component county societies, with the request for study and suggestions; and that a draft be then submitted to the Council or Executive Committee for approval before being given to the Committee on Legislation for action, as agreed upon at the October 6 meeting of the Council.

21. **Recess.**—At this point a recess of the Council was called for luncheon.

22. **Call to Order.**—The Council was called to order after luncheon at 1:45 by the chairman, T. Henshaw Kelly.

23. **Committee of Five.**—The secretary read a letter from Alson R. Kilgore, acting secretary of the Committee of Five stating that the committee at its last meeting recommended that a special meeting of the House of Delegates be called during December for the purpose of considering a preliminary report of the committee embodying a plan for compulsory health insurance and a plan for voluntary health insurance, with arguments for and against.

Full discussion was then had of the time for such meeting. It was felt that the report should be considered by the Council before presentation to the delegates. The necessity of action before the adjournment of the January session of the legislature was discussed. The desirability of the councilors discussing reports in the respective counties in order to obtain the viewpoint and consideration of the profession at large was pointed out.

The Council felt that a special meeting of the House of Delegates should be called prior to January 15, 1935, at such time and place as the Council deems proper.

Action by the Council.—On motion of Kress, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That a special meeting of the House of Delegates be called prior to January 15, 1935, at such time and place as the Council deems proper, said meeting to be a two-day session, commencing at 1 p. m. Saturday and lasting through Sunday.

Action by the Council.—On motion of Pallette, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the members of the California Senate Interim Committee and their secretary be invited to attend the December meeting of the Council.

It having been reported that a member of the Committee of Five on Survey of Medical Services was appearing before civic organizations, in the name of the committee, to discuss health insurance and urging a plan of compulsory insurance, the following resolution was adopted on motion of Pallette, seconded by Peers and unanimously carried:

Resolved, That the secretary be instructed to write to the members of the committee to call their attention to the agreement and understanding that members of this committee would not engage in a discussion of the subject of medical economics or the work of the committee; and be it

Resolved, That the Council considers such discussions and public appearances to evidence disloyalty to the best interests of the profession and future appearance before public audiences by committee members be not approved.

24. **Arrangements Committee.**—The secretary stated that in accordance with constitutional provision the chairman of the Council had appointed as members of the Arrangements Committee Hartley G. Dewey, Yosemite, chairman; C. G. Toland, Los Angeles; Lemuel Adams, Oakland; Robert Peers, Colfax; and Eleanor Seymour, Los Angeles.

Action by the Council.—On motion of Harris, seconded by Kiger and unanimously carried, the following resolution was adopted:

Resolved, That the Committee on Arrangements as appointed by the chairman be approved.

25. **Committee on Economic Security.** — Discussion was had of the desirability of representation of the profession on the Federal Committee on Economic Security.

Action by the Council.—On motion of Kress, seconded by Kiger and unanimously carried, the following resolution was adopted:

Whereas, The California Medical Association, representing the medical profession of the State of California, knowing that the President's Committee on Economic Security proposes to draft and recommend to him a plan for providing medical and hospital care for certain classes of citizens; and

Whereas, The organized medical profession believes, because of first-hand knowledge possessed by its members concerning the incidence and effects of sickness and injury, that a representation of the profession on the President's committee could be of great value in the deliberations; therefore be it

Resolved, That the California Medical Association, through its Council, in regular meeting assembled on November 10, 1934, herewith respectfully urges Secretary of Labor Perkins that she recommend that on the President's Committee on Economic Security there shall be appointed at least one member of the medical profession whose affiliations are such that he will be in a position to present the viewpoints of organized medicine as represented by the American Medical Association (an organization of more than one hundred thousand licensed physicians that has accumulated a vast store of information concerning sickness insurance), and which Association, in the solution of this important social problem because of that work, should be of great value to the President's Committee on Economic Security and to the people of the United States.

26. **President's Badge.**—Doctor Toland stated that he had discussed with the secretary the desirability of presenting all past presidents with a small gold badge bearing the name of the Association and the date of presidency and continuing this practice hereafter.

Action by the Council. — On motion of Pallette, seconded by Howson and unanimously carried, the following resolution was adopted:

Resolved, That a committee, consisting of the president and the secretary, prepare a badge for presentation to the living ex-presidents and that a similar badge be presented to each succeeding president of the California Medical Association.

27. **Los Angeles County General Hospital.**—Doctor Kress stated that it had finally been possible to give the medical and osteopathic units of the Los Angeles County General Hospital separate and distinctive names and that a new system of admission of patients had been adopted on November 1.

Action by the Council.—On motion of Kress, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That the Council is gratified to learn that the Los Angeles County General Hospital, consisting of the two different hospitals, the Los Angeles County Hospital (which is staffed exclusively by doctors of medicine) and the Los Angeles County Osteopathic Hospital (which is staffed by doctors of osteopathy) has completed arrangements for the admission of patients, whereby the patients will themselves indicate their choice of hospital prior to admission.

28. **Los Angeles County Medical Association Home.**

Action by the Council.—On motion of Schaupp, seconded by Rogers and unanimously carried, the following resolution was adopted:

Resolved, That the Council, on behalf of the California Medical Association, congratulate the Los Angeles County Medical Association on the completion of the splendid headquarters building and library structure which it has erected at Wilshire and Westlake avenues, not only because of the manifold benefits it will bring to the members of one of the largest county societies in the United States, but because it will be an inspiration to medical organizations both within and without the State to make efforts to accomplish similar beneficent results for themselves.

29. **Membership.**—The secretary explained the provisions of the American Medical Association governing membership of physician in an adjacent State.

It was the sense of the Council that the secretary write the secretary of the Nevada State Society calling attention to this provision so that the records may be clear.

30. **Ross-Loos Appeal.** — The Council resumed its deliberations in the appeal of Doctors Ross and Loos. The secretary called the roll, and the following councilors were recorded as present: Toland, Pallette, Kelly, Schaupp, Roblee, Ullmann, Phillips, DeLappe, Rogers, Tanner, Kiger, Gibbons, and Harris.

The chairman interrogated these councilors as to whether they had read the first two briefs. All affirmed that they had. The chairman then read the appellants' reply brief.

A general discussion was engaged in, but no definite action was taken at this time.

On motion duly made, the chairman, Mr. Peart, and the secretary were appointed to draft the form for the Council's decision and submit the same for approval. The chairman then asked if this met with the councilors' approval, and there being no objection it was so ordered.

The chairman stated that the Council would now adjourn to meet at the call of the chairman for the purpose of completing its deliberations.

T. Henshaw Kelly, *Chairman.*
F. C. Warnshuis, *Secretary.*

(To be continued)

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of November 15 at the Eureka Inn. Dinner for twenty-four members was served at 6:30 o'clock.

The meeting was presided over by O. R. Myers, president. The following officers were elected for the coming year: President, Charles C. Falk, Jr.; vice-president, J. F. Woolford; treasurer, John A. Lane; secretary, Lawrence A. Wing; delegate, O. R. Myers; alternate, Wilson Stegeman.

Guests for the evening were: Dr. Francis S. Smyth of San Francisco, who spoke on *Juvenile Allergy*; James F. Rinehart of San Francisco, who spoke on *Rheumatic Fever and Its Relation to Vitamin C*; and Stacey R. Mettier on *Purpura*. The visiting doctors were well received and gave an excellent meeting to our Society.

The Society voted to invite the local pharmacists and dentists to a meeting in December.

Lawrence A. Wing, *Secretary.*

ORANGE COUNTY

The regular meeting of the Orange County Medical Association was held on December 4 in the chapel of the Orange County Hospital, with Doctor Huffman in the chair.

The application of Dr. Russell I. Johnson was read for the second time, and he was unanimously elected to membership. Following this, the 1935 election of officers was held, and in each case the following officers were unanimously elected: President, R. E. Hawes; vice-president, John Ball; secretary-treasurer, W. S. Wehrly; librarian, C. D. Ball. H. G. Huffman, councilor (1935-1937) to replace D. R. Ball. Delegates: H. G. Huffman to replace John Clark; G. W. Olsen to replace J. L. Maroon. Alternates: F. H. Gobar for D. R. Ball; M. Hollingsworth for H. G. Huffman; R. P. Yeagle for G. W. Olsen.

President-elect Hawes gave a short speech following his election. Dr. M. Hollingsworth introduced Dr. Samuel Ayres, the speaker of the evening, who chose as his subject *Diet and Dermatology.* During the discussion which followed this most interesting talk, Doctor Chase remarked on the ill effects of chocolate and cocoa iodin salts, and the x-ray as a help in acne. Doctor Olson asked about the use of bismuth in the treatment of the common wart and Drs. John Wehrly, M. Hollingsworth, and Russell Johnson offered remarks.

Miss Eloise Hafford of the Ruth Home spoke on the origin and purpose of the Home, after which the meeting adjourned.

* * *

On December 7 a special meeting of the Orange County Medical Association was called in the usual place, the purpose of which was to discuss the San Fernando plan and its applicability to Orange County. Doctor Harwood acted as chairman, and Doctors Sigworth and Haskins of Long Beach were the invited guest speakers. Supervisors Smith and Lyons were also present.

A lengthy discussion was held as to the merits of this plan, and it was pointed out that it saves the taxpayers' money maintains the physician-patient relationship, and partially pays the overhead expense of the doctor's office. It was agreed, however, not to adopt any resolution at this time, but to wait until the next regular meeting.

On the motion of W. P. Baker, seconded by Clark, the following resolution was unanimously adopted:

"That in view of the opinion of the Appellate Court, rendered in the Third Appellate District of the State of California, in the case of *Armstrong* vs. *Wallace,* the firm of Head, Wellington and Jacobs, attorneys-at-law, of Santa Ana, be authorized to represent the Orange County Medical Association, without cost to said Association, for the purpose of appearing in the Supreme Court of the State of California, in an endeavor to obtain a rehearing in said case."

Waldo S. Wehrly, *Secretary.*

PLACER COUNTY

The annual meeting of the Placer County Medical Society was held at the Freeman Hotel, Auburn, November 17, 1934. In the absence of the president and vice-president, Past President Robert H. Eveleth of Roseville occupied the chair. There were present the following members and visitors:

Members—Drs. Robert H. Eveleth, Paul D. Barnes, Max Dunievitz, C. Ettrick Lewis, H. N. March, Adrian F. Crossen, Ray C. Atkinson, Lucas W. Empey, Mildred E. Thoren, C. Conrad Briner, and Robert A. Peers.

Visitor—Dr. A. Traum of Weimar.

The following officers were elected for the ensuing year: President, Louis E. Jones of Roseville; vice-president, C. Ettrick Lewis of Auburn; secretary-treasurer, Robert A. Peers of Colfax. Delegate to State meeting, Lucas W. Empey of Roseville. Alternate, Mildred E. Thoren of Weimar.

Following the consideration of routine business and correspondence, the secretary gave a short review of the work of the Medical Economic Survey Committee and requested the coöperation of the members. The secretary called the attention of the members to the advantages of membership in the Medical Society of the State of California. Robert A. Peers, *Secretary.*

SACRAMENTO COUNTY

A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. O. F. Johnson, on the evening of September 18, 1934, at the Elks Temple.

Seventy-eight members and guests were present. Due to the length of the program the minutes of the last meeting were not read.

The paper of the evening, *Fractures,* by Dr. Emmet Rixford of San Francisco, was a masterly discourse on the mechanics of fractures, classification of fractures, and methods of reduction. Doctor Rixford illustrated his talk with drawings and x-ray films.

Appreciation of the paper was voiced by Doctors Brendel, McNeal, Schoff, Wallerius, and Wilder.

It was learned at this time that Dr. Philip Young had passed away at his home from a sudden illness. The president ordered the meeting adjourned in respect to Doctor Young.

Just as the meeting was adjourned, Dr. Schoff called the attention of the assembled doctors to Amendments 9 and 17, which would appear on the November ballot. He requested the doctors to do everything in their power to defeat these two amendments.

* * *

A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. O. F. Johnson, on the evening of October 16, 1934, at the Elks Temple.

Seventy-two members were present. The minutes of the last meeting were read and approved.

A suggestion was made that a floral piece be sent in recognition of Dr. Stanley Stillman, who passed away, as a token of respect from the Society.

The paper of the evening, *Empyema,* was given by Dr. Leo Eloesser. He opened the paper by discussing types of empyema. Most of them follow pneumonia. A few, especially in children, may occur without pneumonia. After outlining the diagnosis, he discussed methods of treating empyema, saying that the question of treatment was greater than that of diagnosis. The paper was illustrated by lantern slides. Appreciation of the paper was voiced by Doctor Rulison.

The application of Dr. Clarence W. Kilcher was read before the Society for the second time and, according to the constitution, was voted upon. Doctor Kilcher was unanimously elected to membership in the Sacramento Society for Medical Improvement.

A letter of appreciation from Mrs. Young was read.

The president reported on the postgraduate courses soon to be launched in Sacramento, and appointed the following Committee of Arrangements: Drs. Hilding Johnson, Herbert Burden, M. L. Azevedo, and Cordes Ankele.

Dr. Dave Dozier announced a meeting of the Northern District Medical Society to be held in Sacramento the afternoon of November 23, 1934.

FRANK W. LEE, *Secretary.*

SAN BERNARDINO COUNTY

A meeting of the San Bernardino County Medical Society was held at the County Hospital on November 13, 1934. The meeting was opened by the president at 8 p. m. About 125 members and guests were present. The application of Dr. C. N. Abbott was voted on and approved. Because of the length and importance of the program, further business was postponed.

Mr. Harold P. Thoreson, director of San Bernardino County SERA, first explained that there had been no SERA medical program since July 1, 1934, because the state organization had made no provision for a medical program, and inasmuch as the county case load was so heavy, in proportion to the amount of county funds, these funds had to be used for food, shelter, etc., leaving no available money to continue the medical program. The program which had been in operation was financed by county money.

He spoke of the great need of a medical program and then proceeded to outline his plan for an SERA medical program as follows:

1. That the Society request Governor Merriam to appoint a physician on the board of eleven which is to administer the funds created by the recent State bond issue for relief.

2. A committee from the medical society to administer the medical program, subject to Mr. Thoreson's supervision. He earnestly requested close coöperation between this committee and the SERA office.

3. One full-time physician to be a member of Mr. Thoreson's staff, the physician to be appointed upon recommendation from the committee from the medical society. The duties of this physician to be administrative in character, the actual medical and surgical work to be done by private physicians of the patient's choice on an open-panel basis.

4. The schedule and the other details to be worked out with the medical committee.

The six so-called clinics contemplated, Mr. Thoreson explained, are not to be clinics in the usual sense of the word, but merely welfare headquarters to which patients may go to be directed to a private physician. They may also serve as branches of the County Health Department. They are to be administrative in character, and not diagnostic or therapeutic.

With some county money now available, Mr. Thoreson felt this plan could be started by December 1, 1934, and continued from January 1, 1935, by utilizing some of the money from the State bond issue voted November 6, 1934. Throughout his talk Mr. Thoreson stressed the coöperation between his office and the medical society, and finished by saying that the committee from the county medical society, composed of Doctors Hilliard, Emmons, and Hull, was to administer the medical program. There were some questions and discussion in regard to the clinics. Mr. Thoreson explained again that they were not to be clinics in the usual sense of the word.

Doctor Roblee, the district councilor, urged the members to fill out and return the medical schedules sent by Doctor Dodd, relative to the California Medical Economic Survey, the entire success of this survey depending on the return of the properly filled out schedules.

The county constitution should conform to the constitution of the California State Medical Association. Dr. E. J. Eytinge assured Doctor Roblee that this had already been done in San Bernardino County.

In closing, Doctor Roblee warned against county societies starting lawsuits without informing the State Association and asking for advice, and pointed out that huge amounts of money had been spent by the State Association in carrying cases to higher courts in order that a precedent would not be created that would affect the State as a whole. The lack of funds in smaller societies has made it necessary for the State Association to do this in several instances.

Dr. Clarence G. Toland, president of the State Medical Association, gave a short address, lauding the doctors' victory in defeating Propositions 9 and 17 in the November election, and cautioned against the future, stressing the continuance of our political organization. A basic science law is to be the next objective. In closing he made a plea for closer fellowship among the medical profession.

Dr. Harry Wilson, secretary of the Los Angeles County Medical Society, gave a brief and interesting account of the history and great difficulties he encountered while working out a medical relief program. One-third of his time was spent in this direction without results.

Doctor Warnshuis, secretary of the State Medical Association, spoke on the work of the American Medical Association, the state and county associations, and how they were all working for the good of the individual physician. The State Association at present has two plans started—one for postgraduate medical work, and another to educate the public in good medicine.

Dr. Edward M. Pallette, speaker of the House of Delegates of the State Association, gave a short résumé.

The president thanked the visitors for the honor they had done us in attending the meeting.

Motion was made by Dr. P. M. Savage, Sr., seconded by Dr. C. C. Hilliard, that the Society pass a resolution supporting Mr. Thoreson in his program as outlined, and extend to him a vote of appreciation and continued coöperation. The motion was passed.

Dr. F. F. Abbott made a motion, seconded by Dr. C. G. Hilliard, that a resolution be passed instructing the secretary to write Governor Frank Merriam, asking him to appoint a medical man to the board of eleven men which will administer the funds created by the recent bond issue.

Doctor Hilliard suggested an amendment to the motion, using the word "insist" instead of "request." After some discussion, Doctor Hilliard withdrew his amendment. The original motion passed.

Doctor Finkelberg suggested that Senator Ralph Swing be approached first in regard to asking the Governor to appoint a physician to the board. This was later made in the form of a motion, seconded by Doctor Champion and passed.

Doctor Savage suggested that the Public Relations Committee see both Senator Swing and Mr. Grier in regard to the physician's appointment.

Dr. C. Toland explained that the State Association is endeavoring to have Dr. F. C. Warnshuis appointed.

Dr. F. F. Abbott made a motion, seconded by Doctor Eytinge, that the SERA Committee be given authority to select a doctor for the full-time position in Mr. Thoreson's staff. Motion passed.

The meeting of December 4, 1934, was called to order by the president at 8 p. m. About seventy-five members and guests were present.

A letter of appreciation and thanks for the loan fund from Dr. Giddings Slater was read. Doctor Baylis' report from the Committee on Public Medical and Surgical Service was read. The applications of Dr. H. O. Beeson and Dr. Philip M. Savage, Jr., were favorably voted upon.

Mr. Harold P. Thoreson, San Bernardino County SERA Director, outlined in detailed the medical relief program, to start December 6, 1934. Sample forms were distributed and explained in detail. After answering numerous questions, Mr. Thoreson was given a loud round of applause from the Society in appreciation for his work. Various members expressed their gratitude to Mr. Thoreson and the SERA Medical Committee for planning such a splendid program.

Mr. Thoreson announced that Dr. James W. Moreland had been appointed as the medical director on the SERA staff.

Mr. Thoreson explained that $500 was available to examine five hundred of the most needy working on relief projects, the medical director to select the patients from the histories.

It was moved and seconded that the Society accept Mr. Thoreson's offer and examine these persons whose histories have been taken, at $1 per capita, the examination to consist of necessary physical examination and specific gravity, sugar and albumin of the urine.

The program of the evening was as follows:

Hemorrhoids and Myles' Hemorrhoidectomy by Dr. Donald Brumbaugh. Discussion by Dr. C. G. Hilliard.

Local Anesthetics Producing Prolonged Anesthesia for the Elimination of Pain After Rectal Operations by Dr. Norman J. Kilbourne of Los Angeles. Discussion by Dr. A. D. Neubert.

A. E. Varden, *Secretary.*

SAN JOAQUIN COUNTY

The annual meeting of the San Joaquin County Medical Society was held at the Hotel Clark Thursday evening, December 6, 1934, at 8:20 o'clock. Dr. P. B. Gallegos presided.

The Admissions Committee reported favorably on the application of Dr. I. B. Thompson of Stockton, and he was declared elected.

The annual report of the secretary-treasurer was read and approved.

Dr. Frank McGuire, chairman of the tellers, reported the results of the election for officers as follows: President, C. A. Broaddus; first vice-president, T. C. O'Connor; second vice-president, John Blinn; secretary-treasurer, G. H. Rohrbacher. Directors: Dewey Powell, G. H. Sanderson, J. F. Doughty, C. F. English, P. B. Gallegos, H. S. Chapman, and Hudson Smythe. Delegates: Dewey Powell, C. A. Broaddus. Alternates: Margaret Smyth and R. T. McGurk.

Dr. Dewey Powell read an obituary on the death of Dr. Eisuke Ishikawa and moved that a copy of this tribute be filed with the minutes of this meeting, a copy to be sent to Kenso Ohashi, friend and guardian of the minor children, and a copy to be sent to Grace, a daughter, and Robert, a son. This was seconded by Doctor Dameron, and passed.

Doctor Dameron moved that the Maggs children and the Ishikawa children be given Christmas presents from the medical society. This was seconded by Dr. B. J. Powell, and passed.

The speaker of the evening was Dr. H. Barkan of Stanford University, who presented a paper on the *History of the Spectacle.* This was intensely interesting and carried the manufacture and sale of these appliances back to their first recorded appearances in history in the late thirteen hundreds. The paper was illustrated by slides. Drs. B. J. Powell, Broaddus, Dameron, and Barkan discussed the paper.

G. H. Rohrbacher, *Secretary.*

SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held on Monday, December 10, 1934, at Bissell Auditorium of the Cottage Hospital.

Due to the importance of the meeting, invitations were sent to both Ventura and San Luis Obispo county societies, and many members from each of these societies were present.

Doctor Ullmann then introduced the speaker of the evening, Dr. F. C. Warnshuis, secretary of the California Medical Association. Doctor Warnshuis' address was *Pending Problems in Medical Economics,* and was extremely interesting as well as being of immense value to the profession. At the conclusion of the address various questions were asked and discussed by the attending membership.

Doctor Gray reported for the community medical service, with resolutions. It was moved by Doctor Robinson, and seconded by Doctor Bakewell, that the recommendations as proposed by Doctor Gray's committee be adopted. After discussion the recommendations were adopted by a unanimous standing vote.

Doctor Shelton read the minutes of the last meeting of the Council of the Society, and upon ballot all recommendations were confirmed and the minutes attached as part of the regular minutes of this meeting.

The application of Dr. Caleb S. Stone for membership was read, and upon ballot he was unanimously elected into the Society.

It was moved, seconded and carried, that the Society donate $10 to the Santa Barbara associates toward building a float for the New Year's parade in Pasadena.

William H. Eaton, *Secretary.*

SANTA CRUZ COUNTY

PERCY TODD PHILLIPS

1869-1934

Whereas, Almighty God in His infinite wisdom, on October 28, 1934, closed the career of Percy Todd Phillips, M. D., F. A. C. S., a member of the Santa Cruz County Medical Society since 1905; and

Whereas, In the practice of his profession Doctor Phillips displayed in a high degree the best qualities of a true physician, as manifested in unfailing devotion to the welfare of his patients, in unsparing self-sacrifice in their service, and in the fearless exercise of his trained judgment and skill in their behalf; and

Whereas, In addition to the tireless performance of his professional duties, Doctor Phillips gave much of his time and thought to State and local affairs, having served with outstanding ability for many years as president of the California State Board of Medical Examiners and in various official capacities in the county and city of Santa Cruz; therefore be it

Resolved, That the members of this society hereby express their profound sorrow in the loss of a distinguished fellow member, and their sense of what his loss means to the profession, to his patients and to the community, by the ending of his benign influence among us; and be it further

Resolved, That these resolutions be spread on the minutes of the Society, that copies be sent to the members of Doctor Phillips' family with an expression of sincere sympathy in the great loss which they have sustained, and that adjournment of the meeting this evening be in his memory and in grateful appreciation of his life work in the causes of medicine and humanity.

SOLANO COUNTY

The members of the Solano County Medical Society held a joint meeting with members of Marin, Napa, Sonoma, and Mendocino county medical societies at the Napa Country Club on Saturday, October 13, 1934. About seventy members of the various societies, and guests were in attendance.

The meeting was preceded by a dinner at seven o'clock and was followed by a program of speaking. The guest of the evening and the main speaker was

Dr. Clarence G. Toland of Los Angeles, president of the California State Medical Association. He spoke on the work of the State Society and urged the entire membership to coöperate in trying to do their utmost for the betterment of our profession. Other speakers on the program were: Dr. Junius Harris of Sacramento, past president of the California State Medical Association; Dr. Alson R. Kilgore of San Francisco, Dr. Edward M. Pallette of Los Angeles, Dr. James Toner, Director of State Institutions; and Captain McDonnell, United States Naval Medical Corps, Commanding Officer of the Mare Island Naval Hospital.

Dr. Dwight H. Murray, president of the Napa County Medical Society, acted as master of ceremonies for the evening, and was assisted by Dr. Fred Heegler of Napa and Dr. M. M. Booth of St. Helena.

* * *

The Vallejo members of the Solano County Medical Society held a joint meeting with members of the Vallejo Tuberculosis Association at the Hotel Casa de Vallejo on Monday evening, November 5, 1934. Dr. John W. Green, president of the Solano County Medical Society, presided at the meeting, at which about twenty-five members of both societies were present.

At this meeting plans were outlined to conduct a case-finding study in the Junior and Senior High schools of Vallejo for the purpose of finding out the number of tubercular suspects. Lieutenant-Commander Lynn Hart, United States Navy, of the Mare Island Naval Hospital, was named to assist Vallejo physicians in carrying on the tests, which will consist of (1) performance of the Manteaux test, (2) and if indicated, x-ray of the suspicious cases.

This is the first time in the history of Solano County that such a case study has been carried out, and the physicians are looking forward with a great deal of interest to the results obtained.

* * *

The first annual joint meeting of the Solano County Bar Association and the Solano County Medical Society was held at the Hotel Casa de Vallejo on Tuesday evening, November 13, 1934. About fifty members of both societies and guests were in attendance.

The meeting was preceded by a dinner at eight o'clock at the hotel, followed by a program of speaking, at which Attorney Joseph N. Sweet of San Francisco was the main speaker. He chose as his topic, *Problems and Opportunities of Our Professions.* The talk was well received, and following his address the paper was discussed by members of both societies.

Because of the success of this meeting, it was decided to make the meeting of the Solano County lawyers and physicians an annual affair.

* * *

Through the courtesy of Dr. James J. Hogan, past president of the Solano County Medical Society, and at present an honorary member, the members of the Solano County Medical Society were invited to be his personal guests at a dinner given in honor of Rear Admiral J. Rossiter, United States Navy, Surgeon-General of the Unitel States Medical Corps. The dinner was held at the Hotel Casa de Vallejo on Tuesday evening, November 27, with about fifty guests from the Mare Island Naval Hospital at Vallejo, Napa, Suisun, and Benicia attending.

President John W. Green and Secretary Ambrose J. Ryan of the Solano County Medical Society were called upon by Dr. James Hogan, toastmaster of the evening, for remarks. Both responded, commending the coöperation between the Mare Island Naval Medical Corps and the Solano County Medical Society.

The affair was a very decided success, and the members of the Solano County Medical Society sent a letter to Doctor Hogan for his kindness in extending them the invitation to be present at this dinner in honor of Rear Admiral J. Rossiter.

* * *

The regular monthly meeting of the Solano County Medical Society was held at the Hotel Casa de Vallejo on Tuesday evening, December 11, 1934, at eight o'clock, President John W. Green presiding.

Out of respect to the memory of the late Drs. P. B. Fry of Benicia and Vance Clymer of Fairfield, the members stood in silence for one minute.

A motion was made by Dr. Ream S. Leachman, and seconded by Dr. E. A. Peterson, to have the members of the Solano County Medical Society go on record as being officially opposed to the granting of a permit to a San Francisco firm for garbage disposal in the northern part of Solano County. This motion was carried, and the secretary was instructed to write a letter to the Solano County Board of Supervisors to advise this organization of its official move.

Communications from the University of California Medical School were read announcing the holding of a postgraduate course at the Sacramento County Hospital on Friday evening, December 14. The members were urged to attend, if possible.

A letter from Miss Roxie Alexander, president of the Vallejo Tuberculosis Association, was read. In her letter Miss Alexander extended the thanks of the Vallejo Tuberculosis Association to the Solano County Medical Society in their aiding in the recent case-finding survey.

Dr. Dwight Murray, president of the Napa County Medical Society, who was present at the meeting, invited the members to attend the regular monthly meeting of the Napa County Medical Society at the Depot Inn, Napa, on Thursday evening, December 13.

A report of the recent case-finding study, carried on by the Solano County Medical Society in coöperation with the Vallejo Tuberculosis Association, was read by Miss Irene Carlson, R. N., of San Francisco. Miss Carlson is attached to the California State Tuberculosis Association, and in her report she outlined the work done up to date and promised a complete report at the January meeting.

Dr. Arvil Chappel, former surgeon of the Napa State Hospital at Imola, was officially received into the Society. Doctor Chappel is now a practicing physician in Vallejo.

Mrs. M. Reedy, representative from the Vallejo Parent-Teacher Association, addressed the members on the subject of *Preschool Examinations.* She stated that there would be about ninety children who would be entering school for the first time next August, and it was the hope of the Parent-Teacher Association that the Solano County Medical Society would coöperate in the work of examining these children. After considerable discussion the members went on record as favoring this project sponsored by the Parent-Teacher Association.

Dr. Edward A. Peterson was named as chairman of a committee to form the Solano County Unit of the California Public Health League.

Following are the new officers for the 1935 term: President, Ambrose J. Ryan of Vallejo; vice-president, Robert Newman of Suisun; secretary-treasurer, Arvil Chappel of Vallejo. Delegate to the California State Medical Association convention, S. G. Bransford of Suisun. Alternate delegate: Warren C. Jenney of Vacaville.

It was regularly moved and seconded, and the motion carried, to raise the annual dues of the Solano County Medical Society from $12.50 to $15. It was pointed out that the extra fee asked would allow the county society to carry on more extensive work.

It was announced that the next meeting of the Solano County Medical Society would be held at the Hotel Casa de Vallejo on Tuesday evening, January 8, 1935. This will be a dinner meeting, followed by a program of speaking.

AMBROSE J. RYAN, *Secretary.*

SONOMA COUNTY

The annual meeting of the Sonoma County Medical Society was held December 13, 1934, in Santa Rosa. Dr. E. J. Finnerty of Sonoma, president of the Society, presided. Twenty-three members and guests were present. This being the annual business meeting,

there was no scientific program. Officers and committees made their annual reports. Many communications were read and discussed.

The following were elected to office for the ensuing year: President, F. O. Butler of Sonoma; vice-president, P. T. Quarry of Santa Rosa; treasurer, Leighton Ray of Santa Rosa; and W. C. Shipley was reëlected secretary. Dr. A. A. Thurlow was elected to succeed himself on the Board of Censors.

The applications for membership of Drs. Clement Stimpson and James G. Anderson, both of Petaluma, having been favorably acted upon by the State Secretary and the Board of Censors, were elected to membership by unanimous vote. Two applications for membership were presented and ordered to take their usual course.

The meeting was well attended and aroused considerable animated discussion. We now have forty-nine members, and look forward to an even more prosperous and effective year than the last has proved to be. What with good scientific programs at our regular meetings and the highly instructive sessions of the extramural teaching—in other words, extension postgraduate work by the University of California Medical School—much is being done to stimulate the activity of our medical profession.

W. C. Shipley, *Secretary.*

TULARE COUNTY

The Tulare County Medical Society met at Motley's Sunday, November 18, 1934, for its regular session. Those in attendance were: Doctors Guido, Wells, Preston, Kohn, P. Miller, Tourtillott, Beck, Rogers, Weiss, Betts, Zumwalt, Matthias, Watke, Parkinson, Rosson, Fillmore, Campbell, Ginsberg, and Brigham.

Various communications were read. Among them was one from Mr. Peart regarding the question of defense and indemnity policies. This was brought to the Society's attention in view of the expiring of Aetna policies, and it was recommended that each member carry a policy with at least two companies as well as his membership in the medical society.

The problem of filling out the questionnaire for the California Medical-Economic Survey was brought to our attention. It was the general consensus of opinion that it was impossible to answer some of the questions with any degree of accuracy, but it was decided to answer as fully as possible those which we were able to, in view of the request.

A nominating committee for next year's officers was appointed, to consist of Doctors Kohn (chairman), Zumwalt, and Ginsberg. Doctor Zumwalt was also asked to report on the feasibility of establishing a branch of the Public Health League here.

The meeting was then turned over to Dr. Alson Kilgore, who presented a paper on the *Diagnosis of Extra-Abdominal Conditions Producing Intra-Abdominal Symptoms.*

Karl F. Weiss, *Secretary.*

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the County Clinic Building on Tuesday, November 13, 1934.

The meeting was called to order by the president, Dr. Charles Smolt, who turned the meeting over to Doctor Felberbaum, chairman of program. Doctor Felberbaum introduced Dr. Norman Kilbourne of Los Angeles, who gave an interesting talk, illustrated by lantern slides, on *Local Anesthesia in Rectal Surgery.*

Those present were: Doctors D. G. Clark, Welch, Strong, Drace, Felberbaum, Coffey, Gronhovd, W. S. Clark, Homer, Jones, MacCoy, and Shore.

Doctor Jones introduced Dr. Victor Parkin of Los Angeles, who gave a most interesting informal talk on *Psychiatry and the Law.*

A short business meeting followed.

The chair stated that the December meeting is usually a dinner and election of officers.

Doctor Coffey made a motion that the December meeting be in the form of a dinner at the Saticoy Country Club. The motion was seconded, and passed. Doctor Strong was appointed chairman for the dinner meeting.

The secretary reported that the application of Dr. G. O. Gronhovd had been passed on by the State Society. Doctor Gronhovd was voted in the local society by a unanimous vote.

Fred A. Shore, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (6)

Kern County.—Merlin M. Taggart.
Los Angeles County.—James DeWitt George.
Orange County.—Russell I. Johnson.
San Francisco County.—Paul Castelhun, William L. Thomson.
Santa Clara County.—Norbert J. Gottbrath.

In Memoriam

Arthur, Samuel Richard, Jr. Died at Sacramento, November 25, 1934, age 29. Graduate of the University of California Medical School, 1931, and licensed in California the same year. Doctor Arthur was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✢

Harding-Mason, John. Died at San Francisco, December 13, 1934, age 72. Graduate of the California Eclectic Medical College, Los Angeles, 1900. Licensed in California in 1901. Doctor Mason was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✢

Ishikawa, Eisuke. Died at Stockton, November 28, 1934, age 51. Graduate of the Tokyo Charity Hospital Medical College, 1907. Licensed in California in 1920. Doctor Ishikawa was a member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.

✢

Lawhead, Hiram Davis. Died at Woodland, November 29, 1934, age 82. Graduate of Cooper Medical College, San Francisco, 1883, and licensed in California the same year. Doctor Lawhead was a retired member of the Yolo-Colusa-Glenn County Medical Society, the California Medical Association, and the American Medical Association.

✢

Sampson, Arthur Fichell. Died at San Francisco, November 27, 1934, age 79. Graduate of the University of Virginia Department of Medicine, Charlottesville, 1878. Licensed in California in 1901. Doctor Sampson was a retired member of the San Francisco County Medical Association, the California Medical Association, and the American Medical Association.

✢

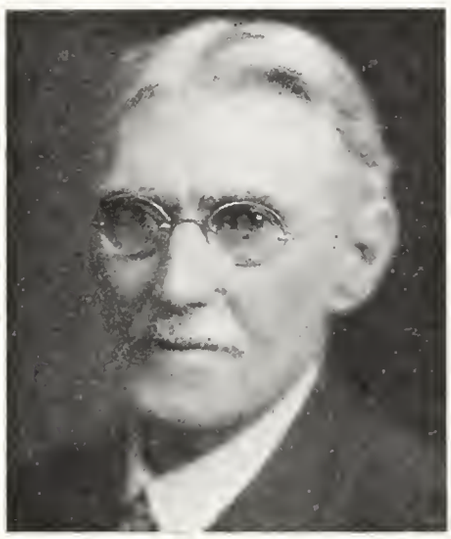
Simmons, Samuel Ewer. Died at Berkeley, November 21, 1934, age 60. Graduate of Harvard University Medical School, Boston, 1899, and licensed in California the same year. Doctor Simmons was a retired member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✢

Smith, Arthur Clarkson. Died at Oakland, November 25, 1934, age 52. Graduate of the Oakland College of Medicine and Surgery, 1907, and licensed in California the same year. Doctor Smith was a member of the Alameda County Medical Association, the California Medical Association, and the American Medical Association.

Clymer, H. Vance. Died in San Francisco, Thursday, September 27, 1934, age 75. Graduate of the Medical Department, Williamette University, Oregon, in 1890, and licensed in California in 1897. Doctor Clymer was a member of the Solano County Medical Society, California Medical Association, and the American Medical Association.

OBITUARY



Hiram Davis Lawhead
1852-1934

On November 30, 1934, at the age of eighty-two, there passed away one of the noblest of the medical profession—one to whom the "Eulogy of the Doctor" by Robert Louis Stevenson truly applies.

Doctor Lawhead was born in 1852 in Belmont County, Ohio. He was the son of a California pioneer and came to California to practice in 1879. He was graduated from Cooper Medical College in 1883, and since that time faithfully served the people of the Sacramento Valley, more especially Yolo County. Note his contribution, "The Relation between the Physician and the Patient," which was published in California and Western Medicine of September, 1926.

Doctor Lawhead was one of the founders of the Woodland Clinic. He took a leading part in the cultural, educational, and political life of the community and served as a citizen in the fullest measure. His entire life was one of service. He will be missed, but his good deeds live after him, and the world is much the better for his having lived.

John Homer Woolsey, M. D.

CANCER COMMISSION*

III†

III. Tumors of the Large Intestine

Introduction

The large intestine in this report includes that from the ileocecal valve to the rectosigmoid junction. Carcinoma, the most frequent tumor of the large intestine, is relatively common, and grows and metastasizes relatively slowly, so that it is a favorable type for cure.

Cancer occurs anywhere in the colon, but its favorite sites are (1) the lower descending colon and sigmoid, (2) the cecum, (3) the hepatic and splenic flexure, in the order named.

The symptomatology depends on the portion of the colon involved, and so consideration of the formation and function of the two main portions is important.

The cecum, ascending colon, and right half of the transverse colon arise from the midgut, are of relative large size, have large haustrae, expand well, and their content is of a liquid character. Their function is absorption of liquids from the intestinal content, and so obstruction does not ordinarily occur, while toxemia and anemia do.

The left half of the transverse colon, descending colon and sigmoid arise from the hindgut, are of a definite and comparably smaller size, do not distend so early, have less marked haustrae, and their content is of semisolid to solid character. The function is that of a storehouse and conduction tube, and so obstruction is a comparatively early sign and toxemia and anemia are rare.

The cure of cancer of the colon depends upon complete removal of the tumor and its metastases. Since removal of a portion of the colon together with its mesentery is possible without interference with vital functions, this organ is favorable for hopeful cures, provided, however, the lesion can be attacked at an early stage.

A. Recognition.

1. *What symptoms are suggestive of bowel malignancy?*

(a) Disturbance of intestinal function characterized by

1. *Obstruction,* partial or complete, and acute or chronic cramp-like pains, distention, borborygmi, diarrheal movement at times, and often increasing obstipation.

It is of the greatest importance to remember that obstruction caused by cancer of the descending colon and sigmoid especially may be quite complete for several days and then clear up—completely, not to recur for weeks, or even months. The obstruction may be very acute without any previous symptoms. This series of events may, to be sure, be caused by fecal impaction, but when it is seen in individuals of the cancer age, unless operated upon during the attack, x-ray examination should always be done to rule out cancer. A large percentage of cancers causing obstruction are in the curable stage at the first attack, but have metastases by the time another obstruction occurs.

It is not rare to see cancers of the descending colon produce a clinical picture closely resembling that of a smoldering subacute appendicitis, with fever, moderate leukocytosis, with pain and tenderness, and even a mass on the *right* side. At operation the cecum and a part of the ascending colon are enormously dilated, and the surgeon is puzzled to find no cause of obstruction about the hepatic flexure. The transverse colon may appear normal in size. It is easy to miss by palpation a small growth in the left colon. A cecostomy must be done and after convalescence from this, barium enema to determine by x-ray the presence and location of the cancer. In a few cases the cecal dilatation has actually gone on to multiple perforation of the viscus.

2. *Bleeding,* fresh or as tarry stools, as determined by laboratory test.

3. *Mucus,* "slimy stools."

4. *Loss of strength* and often of weight.

5. *Anemia.*

6. *Palpable tumor.*

7. *Dyspepsia,* characterized most often by anorexia, sense of fullness and eructations.

8. Alternating diarrhea and constipation.

B. What Constitutes an Adequate Investigation?

1. A complete history, with special reference to bowel function (number of stools, cramps and gurgling with possible stopping at a certain point), bleeding, weakness, weight loss, and dyspepsia.

2. A complete physical examination with special reference to abdominal masses, liver enlargement and lymph-gland metastases (even in the neck).

3. Digital and proctoscopic examination of the rectum.

* The Cancer Commission was brought into being by the House of Delegates of the California Medical Association to aid in the furtherance of all efforts to combat cancer. The roster of officers and the central office of the Commission to which communications may be sent is printed in this issue of California and Western Medicine (see front cover directory). This is one of a series of reports by special committees of the California Medical Association.

† Part I of this report was printed in the November issue of California and Western Medicine, page 348; Part II in the December issue, page 424.

4. X-ray examination for filling defects, by barium enema, following proper preparation. The filling defect may be annular, polypoid, or obstructing with some spasm, but there is usually always a roughening of the marginal contour. Air instillation following evacuation is also of value in some cases.

5. Stool examination for blood, visible or occult. It is usually visible if colon cancer is present.

6. Blood examination for possible anemia and for Wassermann test.

C. Pertinent Questions:

1. *When is a barium enema contraindicated?*

When there is danger of increasing an obstruction and the diagnosis is relatively certain. When there is, obviously, complete obstruction.

2. *Is a failure of demonstration of a tumor by x-ray study conclusive?*

No, for it may be concealed by an overlapping loop of barium-filled bowel. This occurs most often in the region of the splenic flexure, in the descending colon or in the sigmoid. Examination in the oblique position may obviate this.

3. *If the clinical evidence is strong and the x-ray is unable to support the diagnosis, what should be done?*

An exploratory laparotomy with direct examination by the palpating hand should be made.

4. *When is a sigmoidoscopic examination indicated and how should it be interpreted?*

When the evidence of disturbance in bowel function is located in the sigmoid or at a lower level. The negative evidence of a visible tumor, of obstruction, or of fresh blood or mucus means that one has found only the portion examined free from pathology.

D. Treatment.

The only treatment offering complete cure is surgical excision. Carcinoma of the colon is not commonly sensitive to irradiation and it is not recommended except for tumors of the lymphoma group.

Operation for cancer of the colon should be undertaken only with a background of experience and judgment, and it is not the purpose of this summary to specify details of technique. The committee does, however, feel justified in stating that primary resection without preliminary colostomy is dangerous, especially in the presence of even partial obstruction.

Some tumors, which on palpation and roentgen examination are diagnosed as inoperable because of their extent, are actually operable because a large part of the periphery is inflammatory. Such inflammatory reaction may respond to radiation which must not be of the popularly called intensive type, but prolonged and thoroughly fractionated. Such patients should, therefore, be given a therapeutic test of radiation. If this is done, a definite proportion of patients considered inoperable at first, even after an exploratory laparotomy, will be found operable just as some become operable after colostomy alone.

E. Types of Tumors.

1. *Adenocarcinoma*—a large bulky tumor filling the lumen, may arise from a polyp, ulcerates early, may or may not involve the bowel wall, spreading, and most often seen in the right colon and lower sigmoid. Metastases are relatively early.

2. *Scirrhous carcinoma*—an encircling type of tumor of a fibrosing character involving all walls often in the left colon. Metastases are relatively late.

3. *Gelatinous carcinoma*—of the adenocarcinoma type: bulky, invasive, ulcerating, secretes large amounts of mucus, spreads through to peritoneal cavity, but lymphatic metastases are late. Seen most often in the right colon.

4. *Lymphosarcoma*—has been observed in a small but definite percentage of tumor cases. With an x-ray picture not typical of carcinoma, this possibility must be borne in mind, and in selected cases, course of radiotherapy for diagnosis should be done. If it is lymphosarcoma, repetition of x-ray examination ten to fourteen days after radiation shows unmistakable regression of the growth.

5. *Polyps and adenomata* are not uncommon in the colon and in this region are very definitely precancerous lesions, so much so that in the presence of multiple polyps, bowel resection as a prophylactic measure is probably justified. Polyposis of the colon is remarkable as a familial disease. A number of records are in the literature of families, a majority of whose members over several generations have suffered from polyposis and eventualy developed one or more cancers of the colon.

SUMMARY

1. Carcinoma of the colon is a very curable form of cancer if attacked early.

2. The most important symptoms are:

(a) Obstruction, acute or chronic, partial or complete—may be temporary, and clear spontaneously.

(b) Bleeding.

(c) Alternating constipation and diarrhea.

(d) Anemia (in cancer of the cecum and ascending colon).

(e) Palpable mass in the course of the colon (not disappearing after laxatives or enemata).

(f) Dyspepsia (in cases of cancer of the right colon).

Any of these symptoms suggest the possibility of a cancer of the colon.

3. Any person having a change in bowel habits, especially an elderly person, should be studied completely—history, examination, blood and stool examination, and barium enema x-ray.

4. The treatment is chiefly surgical removal.

Respectfully submitted,

The Committee on Gastro Intestinal Tract Tumors:

John Homer Woolsey, *Chairman*	J. A. Guilfoil
Verne C. Hunt, *Secretary*	O. D. Hamlin
Arthur L. Bloomfield	E. W. Hanlon
Thomas O. Burger	Junius B. Harris
Montrose T. Burrows	F. Royal Hendricks
E. L. Crispin	W. E. Mitchell
Hugh Freidell	E. C. Moore
Ernst Gehrels	Rea Smith
	C. L. Stealy
	R. T. Sutherland

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. PHILIP SCHUYLER DOANE President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

Dates for the 1935 Calendar.—The officers and board of the Woman's Auxiliary to the California Medical Association will hold their third meeting on February 15 at the Women's Athletic Club in Oakland. The president requests a full attendance, as plans for the convention and many other matters of importance will be up for discussion.

From May 13 to 16 the annual convention of the California Medical Association and of the Woman's Auxiliary will take place in Yosemite. There is no more beautiful place in which to meet, and plans for the Auxiliary's program have already been in preparation for many weeks, under the able chairmanship of Mrs. Frederick N. Scatena of Sacramento, assuring

* As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

you of delightful entertainment and the most adequate accommodations for meetings and conferences for the business programs. When the new year dawns, put this date on your calendar and make your reservations early.

On June 10 to 14 the American Medical Association and the National Auxiliary conventions will be held in Atlantic City, New Jersey. Plans for the Auxiliary's program will be announced later.

In August the Pan-American Medical Association's annual cruise offers a tempting bid for the summer vacation. Medical men, their families, and their friends from all the Americas—North, Central, and South—will sail this year for Rio de Janeiro, the Brazilian capital, whose beauty and strange charm are unsurpassed. This will particularly appeal to Auxiliary members who have an interest in the cultural life of our sister republics to the south.

* * *

County Auxiliary Reports

Los Angeles County.—The November meeting, preceded by luncheon, was attended by 168 members. Mrs. John V. Barrow presided and introduced the speaker of the day, Dr. Arthur Torrance, explorer and scientist, who flew to the city from New York in order to keep his speaking engagement with the Auxiliary. Doctor Torrance, who is a Fellow of the Royal Society of Tropical Medicine, has just recently completed a survey for the society, which took him through tropical regions in South America, Madagascar, and Borneo. He told incidents from his experiences among strange lands and strange peoples, and also of the changing methods of scientific research in the field of tropical diseases. He emphasized the increasing importance of the laboratory, often located in the heart of a big city, in solving the riddles of medical problems in far places. Explorers like himself he called the errand boys of science, who bring back to the laboratories the data for their investigations.

Dr. Philip Stephens, president of the Los Angeles County Medical Association, gave a brief talk of appreciation for the Auxiliary's aims and efforts. Mrs. Philip Schuyler Doane, the Auxiliary state president, urged all members to inform themselves upon the subject of animal experimentation, as this subject will undoubtedly be a storm center during the coming legislative session. Mrs. Doane cited two issues of California and Western Medicine, that of May, 1933, with a fine article by Chester Rowell, and the October, 1934, number in which Professor Ivy's article and also editorial references on the subject appear. Both Mrs. Doane and Mrs. Barrow asked that Auxiliary members fully acquaint themselves with the facts of this important question before entering into discussions upon it.

Mrs. Barrow has appeared as speaker for the Auxiliary on two other programs during the month. On December 4, at the meeting of the College of Medical Evangelists' faculty wives, an organization of some 150 members, she told of the work and aims of the Auxiliary, and at the Monrovia district meeting of the county medical society, where both doctors and wives were present, she spoke on *What Our Auxiliary Stands For.* The district groups of the Auxiliary's county organization are becoming more and more important in the affairs of the county, and beginning with the new year a policy of holding several of the regular monthly meetings at one of the district centers will be inaugurated. Mrs. Barrow has announced the January meeting to be held in Glendale, and the March meeting in Santa Monica.

Mrs. Eliot Alden finds herself snowed under with a flurry of names and addresses which have come flooding in for the new County Year-Book and Directory to be issued in January. The annual reports and the new revisions and by-laws which change the county calendar to coincide with that of the State will be included in it.

Mrs. Charles W. Decker, Public Relations chairman, who is doing outstanding work in her post, has just sent letters to the Parent-Teacher Association program chairmen of every school in the city, offering to supply them with qualified speakers on any of the following subjects: child hygiene, mental hygiene, nutrition, eugenics, antivivisection, epidemics, security for the child, food handlers, social hygiene, narcotics. Since each school includes in its programs for the year one on health, it is an admirable idea to do what we can to have the speaker for that occasion an authoritative individual whose scientific training and professional standing are beyond any question.

Mrs. Elmer Belt, *Corresponding Secretary.*

* * *

Orange County.—The Woman's Auxiliary to the Orange County Medical Association held its December meeting in the home of Mrs. G. W. Olson of Fullerton. There were twenty-four members present. During the business session a special item of interest was a letter from Dr. Glenn Curtis, chairman of the Public Health League of California, Orange County Division, expressing his appreciation for the efficient help our members gave in the election campaign to defeat Propositions 9 and 17. Mrs. Ray Green and Mrs. G. W. Olson gave interesting reports of a trip taken to the Ruth Home at El Monte.

The following women were elected to continue in office until April, when the regular election will again be held according to the new resolution adopted: President, Mrs. H. G. Huffman; vice-president, Mrs. D. C. Cowles; secretary, Mrs. K. H. Sutherland; and for treasurer, Mrs. G. W. Olson was elected to succeed Mrs. Paul Esslinger.

Dr. Cassius Paul, a dentist of Santa Ana, was the speaker of the afternoon, using as his subject, *Preventive Dentistry.* It was his purpose, Doctor Paul said, to show what is being done to further disease prevention by the members of the dental profession. He enumerated several factors in the control of dental decay, stressing especially the importance of dental hygiene and care in the prenatal period and early childhood. It has been found that some children show a definite immunity to dental caries. Special work is going on at the present time, attempting to perfect a serum which will, when used, make it possible to establish an immunity. On conclusion of his paper, Doctor Paul showed x-rays of teeth, which illustrated some of the remarks made in his talk.

The meeting then adjourned to enjoy a tea hour presided over by Mrs. C. S. O'Toole and Mrs. E. L. Russel. Hostesses of the day with Mrs. Olson were: Mesdames O'Toole, Russel, Charles Petty, and G. A. Paige.

Elizabeth M. Sutherland, *Secretary.*

* * *

Sacramento County.—The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. Charles Vanina on Tuesday evening, November 20, 1934, with the president, Mrs. Howard Hall, presiding.

The minutes of the last two meetings were read and approved, and new business brought before the meeting follows: Since the passing of Mrs. Burt Howard, our first vice-president, a memorial scholarship fund has been started in her name. The president appointed a committee of Mrs. E. O. Brown (chairman), Mrs. F. P. Brendel and Mrs. Dave Dozier to make a report on a proper gift to this memorial fund, and also to submit a plan which the Auxiliary may adopt to take care of expressions of sympathy by way of benefit to some needy person or institution, such as the Sacramento orphanage.

A communication from the State Board was read recommending that we change our time of electing officers to May instead of January. After some discussion it was moved and seconded that we continue our present plan for the time, and elect our officers for the ensuing year at our January meeting. At our executive board meeting, Mrs. T. Binkly was elected chairman of the Nominating Committee, and Mrs. W. K. Lindsay was elected from the floor. These two

will select a third member and make their report at the December meeting.

A special guest, Mrs. Laura Scudder, was introduced by Mrs. E. O. Brown. Doctor Scudder is a practicing physician in India, and is now studying at Harvard for a year.

Miss Sara Ashly of the Sacramento High School English department was the speaker of the evening. She had brought with her a large number of objects of art from Mexico, where she recently traveled extensively. She described the life and work habits of the natives and her trip through the country.

The meeting was then adjourned and the hostess, Mrs. Charles Vanina, assisted by Mesdames James Coyle, O. S. Cook, W. J. Van Den Berg, J. T. Vance and L. W. Ruddy, served a delightful tea.

Mrs. Frank P. Brendal,
Corresponding Secretary.

* * *

San Diego County.—The San Diego Woman's Auxiliary will remember November for a lively meeting, which was held at the home of Mrs. Charles W. Brown. The Christmas spirit asserted itself in the form of plans to collect gifts for the County Farm. The Nominating Committee submitted its report as follows: President, Mrs. Emil Blace; first vice-president, Mrs. C. M. Hosmer; second vice-president, Mrs. E. H. Crabtree; secretary, Mrs. Hiram Newton; treasurer, Mrs. C. O. Tanner. Members-at-large, Mrs. H. G. Summerlin and Mrs. Hall Holder.

The highlight of the meeting was a delightful illustrated program, which was presented by the school nurses. Tea was served at the close of the business meeting. This occasion was in honor of a group of wives of service doctors who became associate members.

Elizabeth Eager, *Secretary.*

* * *

Santa Barbara County.—The Woman's Auxiliary to the Santa Barbara County Medical Society met at three o'clock on Friday, November 2, at the home of Mrs. Arthur Bruce Steele on Paterna Road. Thirteen members were present.

Mrs. Van Paing presided at a short business meeting. Mrs. Henderson reported a suggestion given her by Mrs. Doane. This was concerning a health institute, an all-day session to be held once a year, at which doctors would give lectures to the public. No action was taken on the proposal at this time, although favorable comments were made.

Mrs. Van Paing asked Mrs. Henderson to talk with Doctor Bishop and proceed, if Doctor Bishop has not already done so, to ask the Board of Education for a visiting nurse, following up the proposal made by Doctor Lamb relative to obtaining records of health and mentality of school children.

Mrs. Van Paing thanked the members who gave their time at headquarters in getting out literature for the purpose of defeating Initiatives 9 and 17 at the recent election. These were: Mrs. Van Paing's sister, Miss Frances Hefeman, Mesdames Spaulding, Wilson, Henderson, Hornbach, Halzman, Tucker, Eaton, and Hunt.

Dr. Howard Eder told us about "Sunshine Cottage." He stated that this institution fills a very important place in building up children who would otherwise be easy victims of tuberculosis. Doctor Eder said the last two years of the economic depression had produced a startling increase in malnutrition. This, together with the epidemic of measles of last spring which left many children in poor physical condition, has made the demand for places at "Sunshine Cottage" greater than ever. The management estimates an average cost of $250 for every patient admitted to the Cottage.

Tea was served by the hostess, assisted by Mrs. Bakerwell and Mrs. Henderson.

Mabel Hunt, *Secretary.*

Santa Clara County.—On November 5 the Woman's Auxiliary to the Santa Clara County Medical Association met for luncheon at the Sainte Claire Hotel. There are sixty-three members in the group, of which Mrs. C. Kelly Canelo is president.

Mrs. Philip Schuyler Doane of Pasadena, president of the State organization, was guest speaker. The Santa Clara County Auxiliary has been just recently organized, and it was a particular pleasure to hear Mrs. Doane, who came to lend encouragement as well as to assist in final arrangements.

Mrs. Dudley P. Fagerstrom, *Secretary.*

NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D.....Associate Editor for Nevada

* * *

E. E. HAMER, Carson City President
R. O. SCHOFIELD, Boulder City.....President-Elect
C. E. SECOR, Elko.....First Vice-President
HARRY W. SAWYER, Fallon.....Second Vice-President
HORACE J. BROWN, Reno.....Secretary-Treasurer

COMPONENT COUNTY MEDICAL SOCIETIES

CLARK COUNTY

The Clark County Medical Society held its regular monthly meeting at the Sal Sagev Hotel on November 13, 1934. About twenty members were in attendance to hear Dr. M. N. Hollingsworth of Santa Ana California, discuss his specialty, *Syphilis.* The doctor brought along for display the remarkable group of ancient books upon syphilis, which he has been collecting from all parts of the world during the past few years.

Doctor Hollingsworth has accumulated a tremendous fund of historical data through the translation of these and other ancient books concerning the origin of the disease; the nature and treatment of it as it occurred a few centuries ago; the evolutionary changes in the severity and care of it since that time. The evidence is quite conclusive that the North American Indians had the disease prior to the visit of Columbus to the American Continent in 1492. And there is definite proof that members of Columbus' crew carried the disease to the European Continent after his first voyage to America. The disease then became prevalent in Spain and Portugal, and in later years its dissemination became complete in many other European countries; and contemporary authors of that period were prone to refer to syphilis as the "black plague" and simultaneously to call it "the French disease," or "the Italian disease," depending entirely, of course, upon the nationality of the writer. The Italian felt it originated within the boundaries of France, and the Frenchman thought the Italian was to blame for its spread. It is known that the disease spread rapidly from one nation to another during that period of time; likewise, that the disease was of a very virulent form and that the mortality rate was extremely high.

There was a widespread belief in several countries of the time that the use of the so-called "sacred wood," known to be nothing but guaiacum, was almost a specific cure for syphilis. Mercury also was used by certain practitioners.

Speaking of his own treatment of syphilis, Doctor Hollingsworth felt that, in general, perhaps the arsenicals were not as effective even in the primary stage of the disease as the bismuth preparations, particularly a compound of the latter, which he himself makes up. In conjunction with the bismuth, he uses a preparation called "Aelon," given intramuscularly with the bismuth injection, which he feels to be a valuable adjunct to the efficacy of the bismuth in that it releases the spirochetes from their affinity to the tissue cells, thereby subjecting them to the direct action of the bismuth. In discussing the treatment of neurospyhilis,

the doctor felt the literature was decidedly misleading in its interpretation of the benefits derived from the employment of hot baths in cases of that type, and from his own experience he had concluded that such treatment was not only valueless but even deleterious because of the weakening effect upon the patient.

Doctor Garrison led in a discussion of certain phases of treatment as outlined by Doctor Hollingsworth.

The Society is deeply appreciative to Doctor Hollingsworth for his instructive talk: likewise, for his effort in bringing along his most interesting collection of ancient books.

In the business session prior to the address by Doctor Hollingsworth, the Society voted to appoint a committee to coöperate with the Washoe County Medical Society to consider legislation brought before the state assembly that might affect the medical profession. President Van Meter appointed Doctors Schofield, Martin, and Balcom to act on the committee, with Doctor Schofield to serve as chairman. There was no other important business.

HALE B. SLAVIN, *Acting Secretary.*

* * *

The Clark County Medical Society held its regular monthly meeting December 11, 1934, at the Hotel Sal Sagev.

Officers for the ensuing year were elected as follows: President, R. D. Balcom of Las Vegas; vice-president, R. O. Schofield of Boulder City; secretary, Hale B. Slavin of Las Vegas.

A round-table discussion of various case histories followed the election, and plans were made to have regular guest speakers on the program for the year 1935. J. N. VAN METER, *Secretary.*

*

WASHOE COUNTY

The annual and regular meeting of the Washoe County Medical Society was held on December 11, 1934, at Sparks, the members being the guests of the retiring president, Dr. H. A. Paradis. There were twenty-four regular members and one guest present.

After the call to order a motion was made and carried, to dispense with the reading of the minutes of the last meeting. Before the dinner the secretary presented for the Society's consideration a copy of the report of the State Relief Committee of the FERA, which was adopted by the Oregon State Medical Society. This contained a fee bill for medical relief. After reading many vital sections, especially those pertaining to the minimized fee bill as adopted by the Oregon State Medical Society in conjunction with the State Emergency Relief Committee of Oregon, the Washoe County Medical Society by unanimous vote instructed the secretary to communicate with the State Director of the Nevada FERA that they would not adopt such a fee bill as was adopted by the State Relief Committee of Oregon. In consideration of the fact that the physicians and surgeons of Washoe County, each and every one of them, had contributed freely and graciously of their services to the poor and the indigent, they felt that, rather than establish a precedent of low fees, they would prefer to continue as they have done in the past. However, the Army fee bill, with which most of the members were acquainted and to which an additional fee bill was appended some time ago by the secretary, with reference to obstetrics and gynecology, was again discussed and it was suggested that as a compromise we adopt the Army fee bill as amended. The secretary was instructed to communicate this decision to the State Director of the FERA at Reno.

A circular letter setting forth the activities of the Society during the year with reference to papers read, and members who responded, together with new members received into the Society, had been sent to every member by the secretary prior to this meeting, which materially curtailed the usual business of the evening.

The secretary-treasurer announced the amount of funds remaining in the treasury. Owing to a fortunate error, as reported at the last meeting, an audit of the books by an expert accountant showed $48.96 balance remaining in the treasury. The indebtedness, therefore, has been reduced by $48.96, showing a balance of indebtedness of $26.23.

The members then did justice to the splendid meal set before them. A feeling of most splendid harmony prevailed and each toasted the other to his good health, and even the health of his grandfather, in extending the greetings for a merry Christmas and a happy New Year. All were feeling jubilant in the belief that the dark clouds of the depression were lifting and the golden dawn of prosperity would soon shine again.

The election of officers for the ensuing year was as follows: President, M. A. Robison; vice-president, David L. Shaw; secretary-treasurer, Thomas W. Bath, making his seventh year in succession in this capacity. Censor, Earl L. Creveling. Delegates to the State convention: Drs. C. W. West, S. K. Morrison, and A. L. Stadtherr.

By motion, dues were raised to $10 for 1935.

THOMAS W. BATH, *Secretary.*

TEN QUESTIONS

(For answers, see below)

1. What legal requirements must you observe in prescribing narcotics?
2. Where may you secure recent literature upon a medical subject?
3. Where can you secure information regarding medical affairs in California?
4. How many members are affiliated with the California Medical Association? What should be the membership?
5. When and where was the California Medical Association organized?
6. Who are the spokesmen for the profession?
7. Where only can narcotic addicts be treated?
8. To whom should illegal practitioners or illegal practices be reported?
9. When do you not receive CALIFORNIA AND WESTERN MEDICINE?
10. When are yearly dues payable?

TEN ANSWERS

(For questions, see above)

1. Secure Federal permit; register with State Narcotic Division; keep a record for two years of all your prescriptions and dispensing; file a report on each case where your prescribing extends over a long period in any one case.
2. Packet Library of the American Medical Association. They will send you a packet of recent articles, which you must return in one week. The fee is twenty-five cents.

 Also from California State Medical Library (San Francisco Branch address is University of California, Second and Parnassus Avenues, San Francisco; Los Angeles Branch address is 737 North Broadway, Los Angeles.)
3. California Medical Association, 450 Sutter Street, San Francisco.
4. Five thousand one hundred and sixty-seven; the country's average is 60 per cent of licensed doctors, hence our California Association should have 6,600 members. Will you not induce some eligible non-member to join?
5. In 1871, in San Francisco.
6. In national affairs, the American Medical Association; in state affairs, the State Association; in county affairs, the county society.
7. In approved hospitals or institutions, never at home.
8. Board of Medical Examiners, Dr. C. B. Pinkham, Secretary, 420 State Office Building, Sacramento.
9. When you are in arrears for dues and when you fail to report change of address.
10. January 1, 1935, to your county secretary.

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Yosemite National Park, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

Medical Broadcasts*

American Medical Association Health Talks.—The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, central standard time.

* * *

San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of January is as follows:

Tuesday, January 1, being a legal holiday, there will be no broadcast.
Tuesday, January 8—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: The Hereditary Transmission of Disease.
Tuesday, January 15—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Mysterious Glands.
Tuesday, January 22—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Middle Life.
Tuesday, January 29—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Ears and Hearing.

* * *

Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of January is as follows:

Tuesday, January 1—KECA, 11:15 a.m. (Holiday.)
Saturday, January 5—KFI, 9 a.m. Subject: Medicine and Human Progress, No. 18.
Saturday, January 5—KFAC, 10 a.m. Subject: Your Doctor and You.
Tuesday, January 8—KECA, 11:15 a.m. Subject: Medicine and Human Progress, No. 19.
Saturday, January 12—KFI, 9 a.m. Subject: Medicine and Human Progress, No. 19.
Saturday, January 12—KFAC, 10 a.m. Subject: Your Doctor and You.
Tuesday, January 15—KECA, 11:15 a.m. Subject: Medicine and Human Progress, No. 20.
Saturday, January 19—KFI, 9:00 a.m. Subject: Medicine and Human Progress, No. 20.
Saturday, January 19—KFAC, 10 a.m. Subject: Your Doctor and You.
Tuesday, January 22—KECA, 11:15 a.m. Medicine and Human Progress, No. 21.
Saturday, January 26—KFI, 9:00 a.m. Subject: Medicine and Human Progress, No. 21.
Saturday, January 26—KFAC, 10 a.m. Subject: Your Doctor and You.
Tuesday, January 29—KECA, 11:15 a.m. Subject: Medicine and Human Progress, No. 22.

University of Oregon.—Dr. Edward S. West, newly appointed professor of biochemistry at the University of Oregon Medical School, has arrived to prepare for the opening of the fall term, coming from Washington University at St. Louis where he formerly held the position of associate professor of biochemistry.

* County societies giving medical broadcasts are requested to send information as soon as arranged (giving station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

American Association for the Study of Goiter.—The American Association for the Study of Goiter again offers the Van Meter Prize award of $300 and two honorable mentions for the best essays on the subject of goiter, provided they meet the standards of the award committee. The essays should be based on original research work on the subject of goiter, preferably its basic cause. The prize essay or its abridgement is to be presented at the annual meeting of the association to be held in Salt Lake City, Utah, in June, 1935.

Competing manuscripts should be in the hands of the corresponding secretary, W. Blair Mosser, M. D., Kane, Pennsylvania, not later than April 1, 1935.

The first prize of $300 for the 1934 meeting was awarded to M. A. B. Brazier, B.Sc., Ph.D., London, England, for her essay, "The Impedance Angle Test for Thyrotoxicosis."

First honorable mention was awarded Prof. Ugo Cerletti, Genoa, Italy, for his essay "Three Years of Experimental Research in the Etiology of Endemic Goiter."

Second honorable mention was awarded D. Roy McCullagh, M. D., Cleveland Clinic, Cleveland, Ohio, for his essay "Studies in Blood Iodin, Using a New Chemical Method."

Alumni Postgraduate Assembly of the College of Medical Evangelists.—The Alumni Association of the College of Medical Evangelists conducted a one-day postgraduate assembly on Sunday, December 9, 1934, in Paulson Hall, 1855 Michigan Avenue, Los Angeles.

The residents and internes of all hospitals within the city, and the senior medical students in the University of Southern California and the College of Medical Evangelists were privileged to attend.

The guest speaker was Bernard Myers, who is president of the Clinical Section of the Royal College of Physicians of London. He was passing through the United States on his way to New Zealand, where he will represent the British Medical Society at the meeting of the New Zealand branch. The University of California was represented by Doctors Kruse, Kilgore and Lisser. The program was as follows:

9:00 a.m.—John C. Wilson, M.D. Fractures and Dislocations of the Upper Extremity. Common Faults in their Treatment.
9:30 a.m.—Bernard Myers, M.D. Essential Thrombocytopenic Purpura Hemorrhagica.
10:00 a.m.—M. N. Beigelman, M.D. Syphilis and Blindness.
10:30 a.m.—E. Earl Moody, M.D. Childhood Tuberculosis.
11:15 a.m.—Donald J. Frick, M.D. Pulmonary Embolism.
11:45 a.m.—B. O. Raulston, M.D. Nephritis.
12:15 p.m.—F. R. Nuzum, M.D. Essential Hypertension: the Possibility of Its Arising from Hormone Imbalance.
2:00 p.m.—J. M. Nielsen, M.D. Mental Symptoms which are not Evidence of Insanity.
2:30 p.m.—W. D. Sansum, M.D. The Favorable Influence of Higher (Adequate) Carbohydrate Diets on the Blood Pressure Problem in Diabetes.
3:00 p.m.—E. S. Kilgore, M.D. Syphilis of Aorta and Heart.
3:30 p.m.—F. H. Kruse, M.D. Diagnosis and Treatment of the More Common Complications of Peptic Ulcer.
4:15 p.m.—H. Lisser, M.D. Three Remarkable Cases of Endocrine Disease; Diagnosis and Treatment.
4:45 p.m.—F. H. Smith, M.D. Diabetes Insipidus: Treatment by Intranasal Insufflation Powdered Posterior Lobe Pituitary.
5:15 p.m.—M. H. Rabwin, M.D.; M. H. Rosenfeld, M.D. Total Thyroidectomy for Heart Disease.
7:00 p.m.—A. B. Cecil, M.D. Surgery of Hypospadias and Epispadias.
7:30 p.m.—C. W. McClanahan, M.D. X-ray Diagnosis of Tumors of the Chest.

Lectures by Dr. Paul J. Hanzlik of Stanford.—Dr. Paul J. Hanzlik, professor of pharmacology, Stanford University School of Medicine, San Francisco, will give a series of graduate lectures on pharmacology and therapeutics during the Christmas holidays, in Seattle. The lectures are sponsored by the Seattle General Hospital and the medical profession of Seattle. Subjects to be considered are intravenous medication, antitoxic and protective actions of dyes and systemic antisepsis, newer metabolic stimulants, digitalis on cardiac output and circulatory states, bismuth in treatment of syphilis, hypnotics and basal anesthesia with barbitals and avertin, drug toxicoses and agranulocytosis, modern views of asthma and anti-asthmatic remedies, newer methods and antidotes in the treatment of acute poisoning.

San Francisco Heart Committee.—The Heart Committee of the San Francisco County Medical Society and the San Francisco Tuberculosis Association held its fifth annual postgraduate symposium on Heart Disease on November 21 and 22, 1934, at the San Francisco, University of California, Mount Zion, and Stanford University Hospitals. The program was arranged by Doctors John P. Strickler, William Dock, Harold P. Hill, William J. Kerr, and John J. Sampson. There was a total attendance of 1,244, an increase of 50 per cent over the previous year. Registrations were received from sixty-nine cities of California.

The following subjects were discussed:

The Heart in Thyroid Disease—Harold H. Rosenblum, M.D.
Gonococcal Endocarditis—Maurice Cohen, M.D.
The Heart in Infectious Diseases—LeRoy Briggs, M.D.
Surgery of the Heart—Harold Brunn, M.D., Albert L. Brown, M.D.
The Heart in Surgery and Obstetrics—John J. Sampson, M.D.
Heart Disease in San Francisco School Children and a Discussion of Vocational Guidance—Anita E. Faverman, M.D.
Coronary Sclerosis; Subacute Bacterial Endocarditis; Arteriosclerotic Heart Disease—Harold P. Hill, M.D., Edwin Bruck, M.D., George Barnett, M.D., John J. Sampson, M.D.
Stetophonic Demonstration of Heart Murmurs—William J. Kerr, M.D.
Electrocardiographic Demonstration—Frederick Kellogg, M.D.
Motion Pictures—(1) Harvey Film on the Circulation of the Blood, (2) Lutembacher Film on Cardiac Irregularities. Presented by John B. Lagen, M.D.
Clinic on Pulmonary Arteriosclerosis—Francis Rochex, M.D.
Relationship Between the Metabolic Rate and Circulatory Measurements—Eric Ogden, M.D.
Clinic on Thyroidectomy in the Treatment of Heart Failure—Richard D. Friedlander, M.D.
Clinic on the Treatment of Congestive Heart Failure—William J. Kerr, M.D.
Clinic on Hypertension—D. W. Bennett, M.D.
X-ray Demonstration of Coronary Circulation Injected with Opaque Medium—J. L. Carr, M.D., R. F. Escamilla, M.D.
Clinical Aspects of Coronary Disease—Garnett Cheney, M.D.
Interpretation of Abnormal Heart Sounds—William Dock, M.D.
The Treatment of Cardiac Arhythmias—J. K. Lewis, M.D.
The Heart in Febrile Disease—Arthur Bloomfield, M.D.
Venesection in Relation to the Blood Volume Changes in Heart Failure—W. Cutting, M.D.
Therapeutics of Hypertension—Thomas Addis, M.D.

The annual meeting and election of officers of the Heart Committee was held in connection with the closing session of the symposium at the San Francisco County Medical Society. The newly elected officers for the year 1935 are: Chairman, John J. Sampson; vice-chairman, J. Marion Read; secretary, John P. Strickler.

The business meeting was followed by a clinical pathological conference and a symposium on Thyroidectomy in the Treatment of Congestive Failure and Angina Pectoris, in which the following doctors participated: William Dock, Richard D. Friedlander, Gordon E. Hein, Emile F. Holman, William J. Kerr, J. Marion Read, Harold H. Rosenblum, John B. de C. M. Saunders, Henry H. Searls, Jesse L. Carr, and Alvin J. Cox.

Los Angeles Heart Association. — The third annual symposium on Heart Disease by the Los Angeles County Heart Association was held at Los Angeles on December 6 and 7, 1934. The list of speakers follows:

Thursday, December 6, 1934

Embolism as a Manifestation of Heart Disease—E. Richmond Ware, M.D.
Subacute Bacterial Endocarditis—Willard J. Stone, M.D.
Cardiac Neurosis—Egerton Crispin, M.D.
Drug Therapy in Heart Disease—John C. Ruddock, M.D.
The Treatment of Auricular Fibrillation—William H. Leake, M.D.
Thyroidectomy in the Treatment of Congestive Heart Failure and Angina Pectoris—Arthur M. Hoffman, M.D.

Joint Meeting with Los Angeles County Medical Association

The Importance of Early and Accurate Diagnosis in Heart Disease—A. S. Granger, M.D.
Some of Our Less Clear Conceptions of Coronary Disease—Eugene S. Kilgore, M.D. (by invitation).

Friday, December 7, 1934

Clinical Pathological Conference
Discussion of Cases with Demonstration of Specimens

Doctors Newton Evans, E. M. Butt, V. R. Mason, D. D. Comstock, B. O. Raulston, and W. C. Boeck.

Exhibit of Pathological Material

A Cardiac Comparison—Syphilitic and Rheumatic Heart Disease—R. Manning Clarke, M.D.
The Surgical Risk in Heart Disease—Roy Thomas, M.D.
The Heart in Tuberculosis—F. M. Pottenger, M.D.
Abnormalities of the Myocardium—Donald J. Frick, M.D.
The Treatment of Acute Coronary Occlusion—Harold H. Smith, M.D.
The Treatment of Syphilitic Heart Disease—J. L. Maroon, M.D.

Mortality Trends Since 1900.—In a paper presented before the American Public Health Association at Pasadena on September 4, 1934, Louis I. Dublin, Ph.D., of New York City brought out the following points:

The progress of the public health movement in the United States since the beginning of the century can best be measured by the fact that about 600,000 fewer deaths now occur each year than would have occurred if the health conditions of 1900 had continued to prevail. Mortality has been reduced 30 per cent in a little over thirty years. This is the outstanding result of a comparison of the death rates prevailing in the original death registration States at the beginning of the century with those recorded in recent years. For every one thousand of the population, five more survive each year under present conditions who would have died under the old régime.

This improvement in mortality has been achieved almost altogether among persons under forty-five years of age, and more particularly among infants and children. The greatest accomplishment has been the increased control over the communicable diseases, chiefly tuberculosis, pneumonia, typhoid fever, and the diseases peculiar to infancy and childhood. Diphtheria and scarlet fever, which at the beginning of the century were a real menace to child life, are now well on the road to extinction. Measles and whooping-cough have also been greatly reduced. The result of these and other improvements in mortality has been to add eleven years to the expectation of life at birth and even as many as four years to the expectation at age twenty.

After age fifty-five, the net saving in mortality has been practically nil. No headway has been made since 1900 in the fight against the chronic diseases of the more advanced age periods, namely, cancer, diabetes and the diseases which affect the heart, blood vessels, and kidneys. In fact, among persons of advanced age, almost twice as many deaths in a unit of population are attributed to these diseases today as in the early years of the century. In part, this increase is due to improved diagnosis and better methods of reporting. But an actual increase is, nevertheless, in evidence above and beyond this improvement in statistical technique. The success of the campaign for the improvement of the public health in the future will depend in large measure upon further progress in the curtailment of the diseases of middle life.

Address by Dr. Bernard Myers of London.—Dr. Bernard Myers, president of the Clinical Section of the Royal College of Physicians of London, England, addressed the faculty and students at 12 noon on Monday, December 10, 1934, in Toland Hall, University Hospital, San Francisco, on "Essential Purpura Hemorrhagica.

Before coming to San Francisco, Doctor Myers visited New York, where he addressed a group at Columbia University School of Medicine. He was also the guest of honor at the meetings of the Texas Pediatric Society and the Southern Medical Association, in San Antonio, Texas.

On December 12 he sailed for New Zealand, where he will represent the British Medical Society at the meeting of the New Zealand branch.

Western Orthopedic Association.—The second annual meeting was held on Friday and Saturday, November 9 and 10, 1934, at Los Angeles.

There were forty-nine members and guests registered, including physicians from the far Northwest, San Francisco district, Salt Lake, and Southern California. Program follows:

GENERAL HOSPITAL PROGRAM

Internal Fixation of Fragments in Fractures of Neck of the Femur: A New Method—James V. Luck, M.D., Los Angeles.

Simple Devices for Application of Traction to Fractures of Forearm and Leg Bones—E. W. Cleary, M.D., San Francisco.

Interesting Orthopedic Problems from a Diagnostic Standpoint—John C. Wilson, M.D., Los Angeles.

Synostosis of Radius and Ulna—Paul E. MacMaster, M.D., Los Angeles.

Treatment of Chronic Osteomyelitis—Charles L. Hawk, M.D., Hollywood.

Fractures and Dislocations of the Shoulder—William A. Clark, M.D., Los Angeles.

End Result of Complicated Fractures of the Elbow—Alfred E. Gallant, M.D., Los Angeles.

CHILDREN'S HOSPITAL PROGRAM

Skin Grafts—George C. Shelton, M.D., Los Angeles.

Hemophilia Arthritis—Rolla G. Karshner, M.D., Los Angeles.

Bone Tumors—Francis M. McKeever, M.D., Los Angeles.

Congenital Dislocation of the Hip—Steele F. Stewart, M.D., Los Angeles.

Report of the Recent Poliomyelitis Epidemic—Pierre J. Walker, M.D., Los Angeles.

Pathology of Poliomyelitis in the Recent Epidemic—Roy M. VanWart, M.D., West Los Angeles.

Orthopedic Problems of Amebiasis—Brooks P. Stephens, M.D., Oakland.

Capitellar Fractures—Vernon P. Thompson, M.D., Los Angeles.

On Friday evening, November 9, a banquet was held in the dining room of the new Los Angeles County Medical Association's permanent home, 1925 Wilshire Boulevard, Los Angeles.

An address was given by the retiring president, Dr. Steel F. Stewart.

The guest speaker of the evening was W. Mosauer, M.D., Ph.D., University of California, at Los Angeles.

ORTHOPEDIC HOSPITAL SCHOOL PROGRAM

Further Experience with Facial Transplants—Charles LeRoy Lowman, M.D., Los Angeles.

Acute Traumatic Bone Atrophy—Harold D. Barnard, M.D., Los Angeles.

Review of Leg Lengthening Operations—Alvin Brockway, M.D., Los Angeles.

Review of Hip Fusion Operations—R. L. Carroll, M.D., Los Angeles.

Supracondylar Fractures of the Elbow—Ward M. Rolland, M.D., Los Angeles.

Plastic Repair Annular Ligament in Dislocation of the Head of the Radius—Harold E. Crowe, M.D., Los Angeles.

New Skeletal Traction Apparatus—Roger Anderson, M.D., Seattle.

The application of the northern district (Washington and Oregon) for the formation of a parent chapter of the Western Orthopedic Association was received and approved unanimously.

The officers elected for the ensuing year were: President, Lionel Prince; president-elect, Charles LeRoy Lowman; secretary, Merrill C. Mensor; treasurer, Howard H. Markel.

It was voted to hold the next annual meeting in the San Francisco Bay district.

British Doctors Allied to Unions.—The United Press, under date of December 19, printed under the above caption the following interesting item:

"British doctors tonight, for the first time in history, became affiliated with trade-unions.

"The Trade Union Congress announced it had enrolled 3,847 members of the Medical Practitioners' Union, chiefly municipal health officers, and 7,788 members of the National Union of County Officers, including county health officials."

Medical Society of the State of Pennsylvania Dedicates Headquarters and Library Building.—On Tuesday, December 11, 1934, at 230 State Street, Harrisburg, Pennsylvania, a new headquarters and library building was dedicated. Copy of the printed program follows:

"The promotion and dissemination of medical knowledge throughout the State remains our important function."—William Osler, M.D.*

Edgar S. Buyers, M.D., Chairman of the Board of Trustees, presiding.

Invocation: Rev. Wilbur V. Mallalieu, Harrisburg.

Presentation of Keys, by Lawrie & Green, architects, Harrisburg.

Presentation of Building, by Building Improvements Committee of the Board of Trustees—Augustus S. Kech, M.D., Chairman; Clarence R. Phillips, M. D.; Frederick J. Bishop, M.D.

Acceptance of Building, by President Moses Behrend.

Greetings—James N. Rule, A.M., Sc.D., Secretary, Department of Education, State of Pennsylvania.

Greetings—Arthur W. Booth, M.D., Elmira, N. Y., representing Board of Trustees, American Medical Association.

Greetings—Honorable Gifford Pinchot, Governor of Pennsylvania.

Greetings—Theodore B. Appel, M.D., Secretary of Health, State of Pennsylvania.

Unveiling of portrait of the late Cyrus Lee Stevens, A.M., M.D., by Stanley D. Conklin, M.D., representing the Bradford County Medical Society.

Adjournment at 4:30 p.m.

"To infect the young with the reading habit, books must be made accessible."—Harvey Cushing, M.D.

Emergency Funds Speed Eradication of Bovine Tuberculosis.—Emergency funds are speeding up the work of eliminating tuberculous cattle from the herds of the nation. The appropriation under the Jones-Connally Act has already stimulated great activity in eradication work in New York and California, and there has been a noticeable increase in several other States. The Bureau of Animal Industry, United States Department of Agriculture, is carrying on this drive in coöperation with the State livestock sanitary authorities. This special campaign supplements and intensifies the regular work along the same lines.

Part of the Jones-Connally fund pays for operating expenses, but most of the appropriation will go to cattle owners as indemnity payments for reactors that are being removed from herds.

In California the eradication work under the emergency funds is speeding up. In Imperial County, in the southern part of the State, more than five thousand reactors were removed in the first sixty days of testing. The work is now getting under way in the central part of the State and will continue in other areas. Initial testing of all herds in the State probably will be completed before the end of 1935. At present California is making no payments for indemnities for this special testing, but owners of reactor cattle in the State are receiving federal indemnities plus salvage payments.

There is also considerable testing under the emergency funds in thirty-one other States.

The new regulations differ from those used in the regular conduct of the work principally in allowing States to participate in eradication work whether or not they expend any of their own funds for indemnities or for the cost of testing. The total amount received as indemnity from all sources plus the salvage obtained cannot exceed the appraised value or an amount the owner would receive under the existing plan in his State. Payments for cattle found to be tuberculous are on the basis of a maximum of $20 a head of federal money for grade cattle and $50 for registered pure-bred cattle.

*A member of the Medical Society of the State of Pennsylvania, 1886-1889.

Doctor Hamlin Named as Alumni Head of the Stanford Alumni Association.—The San Francisco *Chronicle* printed the following item:

"Following elections held in San Francisco, Dr. O. D. Hamlin, Oakland physician and surgeon, was made the new president of the Stanford Alumni Association, succeeding Dr. Morton Gibbons of San Francisco.

"Doctor Hamlin is one of the founders of the American College of Surgeons, and for long served as a member of the board of governors of the surgical college. He is chief surgeon of the emergency department of the Alameda County medical institutions."

Sale or Dispensing of Dinitrophenol Restricted.—As the product known as dinitrophenol has been known to cause death, evidence of which is officially recorded, and inasmuch as it is the belief of the Department of Public Health that for the protection of the public health such drugs should only be dispensed, prescribed or sold upon prescription or under direction of a licensed physician; be it therefore

Resolved, That from this date the prescribing or dispensing or sale of dinitrophenol by anyone other than a physician licensed to practice medicine in the State of California, is hereby prohibited. Signed, J. D. Dunshee, Director of Public Health. August 20, 1934.

The Rockefeller Foundation.—Some excerpts from an information service bulletin follow:

During 1933 The Rockefeller Foundation appropriated $9,890,806.31 for various philanthropic projects.

Public Health.—The Rockefeller Foundation expended for public health work during the year the sum of $3,286,063.01. It supported laboratories for yellow fever research in Lagos, Nigeria; Bahia, Brazil; and New York City. It completed, in coöperation with various governments of West Africa, an extensive survey which disclosed the areas in Africa where yellow fever occurs; assisted the governments of Brazil and Bolivia in an extensive program of yellow fever control; conducted experiments and studies on the vaccine and virus of yellow fever and on the mosquito vectors of this disease; aided three states in the United States and seventeen foreign governments in antimalaria work; carried out malaria studies and surveys in various parts of the world; engaged in studies of hookworm disease in Palestine, Egypt, Straits Settlements, and Puerto Rico; supported studies of Endameba histolytica, Rocky Mountain spotted fever, tuberculosis, sprue anemia, filariasis, schistosomiasis, and the diseases affecting the races of the Pacific; aided the government of India in conducting experiments on the disposal of refuse; sponsored studies of statistical epidemiology; contributed toward the development of state and local health services of fifteen European countries, the League of Nations, five Far Eastern countries, the government of the South Pacific Islands, six countries of the Caribbean region, two countries of South America, and the governments of Mexico and Canada; gave assistance to the central health administrations of fourteen states in the United States and to the local health administrations of twenty-three states of the United States, four provinces of Canada, and five areas in Mexico, and provided funds for local health units in fourteen other countries; directed the studies of 197 fellows in public health, thirty-two nursing fellows, and six nurse visitors; provided financial aid to former fellows in carrying out special studies; and contributed toward the support of schools of hygiene and public health and of centers of public health training in Japan, Puerto Rico, Central America, South America, Europe, and the United States.

Medical Sciences.—In the medical sciences The Rockefeller Foundation, during 1933, appropriated $1,173,853. In aid of programs of specific concentration in the fields of psychiatry and public health teaching, appropriations were made to the Johns Hopkins University School of Medicine for research in psychiatry; to University College, London, for work in biophysics and neurophysiology; to Washington University, St. Louis, Missouri, for investigations in nerve physiology; and to the Harvard Medical School and Massachusetts General Hospital for coöperative work in psychiatry. For the development of teaching in public health and preventive medicine an appropriation was made to Dalhousie University, Halifax, Nova Scotia. During 1933 the Foundation provided 295 fellowships in the medical sciences. In addition, research aid grants in sums varying from $55 to $3,000 enabled sixty-one scientists or groups of scientists to carry on research work.

Decreased Budgets of Health Organizations.—Greatly decreased financial support for health organizations throughout the country during the past few years has now reached the point where it may bring not only increased sickness and mortality this winter, but also the dissolution of some vital health agencies which have been built up after many years of effort. This is the warning of a committee of the National Health Council in a report made public today by Colonel Theodore Roosevelt, president of the Council. The public and private health resources of the United States, not including the budgets of hospitals, which also suffered heavy losses in support, diminished from $125,000,000 in 1929 to less than $100,000,000 in 1933, the report points out. . . .

Recent Exhibits at the University of California Medical School Library.—In connection with the presentation in Wheeler Hall, Berkeley, of "Yellow Jack," the current dramatic sensation by Sidney Howard, a graduate of the University of California in 1924, Dr. S. V. Larkey arranged a special exhibit of material relating to the conquest of yellow fever, the theme dealt with by the play. Original documents and reprints by Carlos Findlay, Walter Reed, Jessie Lazear, Aristides Agramonte were displayed. Holograph letters and other manuscript material from the late Doctor Agramonte added much to the interest of the exhibit.

During November an exhibit was made of representative bindings of medical classics from the fifteenth to the twentieth century. The oldest binding shown was a late fifteenth century Venetian blind-tooled leather one over oak boards, enclosing commentaries on Aristotle, printed in 1482. The transition from leather-covered oak boards through vellum and calf to current cardboard and cloth bindings was demonstrated.

During December a special exhibit was made of caricatures of some of the members of the faculty drawn by a student of the third-year medical class. These caricatures were first shown at class functions and have now been assembled for permanent deposit in the library. Other caricature material relating to the University of California Medical School was also on display.

Formal Opening of the Library of the Los Angeles County Medical Association.—The formal opening of the library of the Los Angeles County Medical Association proved a notable occasion for members of the Association and their friends. It was held on Tuesday evening, November 27, 1934, at eight o'clock. in the auditorium of the Association, Wilshire Boulevard at Westlake.

Presentation of the Barlow Medical Library was by Dr. George Dock, president, on behalf of the Barlow Medical Library Association.

The acceptance of the Barlow Library was by Dr. Philip Stephens, president of the Los Angeles County Medical Association.

Miss Louise Ophüls of San Francisco, vice-president of the Medical Library Association, extended greetings, being introduced by Mrs. Mary E. Irish, librarian.

The address of the evening was by Dr. Chauncey D. Leake, professor of pharmacology in the University of California School of Medicine, the guest speaker being introduced by Dr. Elmer Belt, vice-president.

A social hour, with inspection of the medical library, followed.

Three Thousand Persons Killed Annually in Shooting Accidents. — During November and December, when the hunting season is at its height, fatal accidental shootings are familiar items in our daily press. It is little realized, however, that year in and year out, about three thousand persons die in the United States as a result of the careless handling of firearms, not only in hunting but in or about the home, and on the streets and highways. In this manner, twenty-four persons out of every million in our population meet death each year. This is nearly twice as many as die by the accidental absorption of poisonous gases of all kinds, whether in homes, by illuminating gas; in garages, by carbon monoxid; or in industry. Traumatism by firearms is sixth in importance as a means of fatal accidental injury, being exceeded only by injuries due to automobiles, falls, burns, drownings, and railroad trains or engines. . . .

The mortality from accidental shooting is notoriously high in the United States. Our death rate of 2.4 per 100,000 in 1933, for example, compares very unfavorably with the rate of .2 deaths per 100,000 for England and Wales, in 1932. . . .

The highest death rates from this type of accident occur in the mountain states of Nevada, Montana, Idaho and Wyoming, the death rates for these four states in the years 1931-1933 being, respectively, 7.6, 6.3, 5.9, and 5.4 per 100,000. . . . California's death rate from accidental shooting is 2.0 per 100,000.

American Board of Radiology to Meet on Pacific Coast.—B. R. Kirklin, M. D., secretary-treasurer of the American Board of Radiology, Rochester, Minn., has sent out a notice that the American Board of Radiology has decided to hold a meeting on the west coast about the middle of May, 1935, at which time candidates will be examined for certificates. The Board has chosen to do this because of the fact that there are a number of applications on file from that section of the country, and it was felt that a meeting should be held at a place where it would be convenient for such applicants to appear before the Board. Anyone who is desirous of appearing before the Board at that time should have his application completed and on file in the secretary's office not later than March 1, 1935.

The minimum requirements for eligibility to make application for a certificate are:

1. Membership in at least one of the national radiologic societies, the American Medical Association, or the Canadian Medical Association.

2. At least three years' experience in radiology during which time not less than 75 per cent of the applicant's time has been devoted to radiology.

3. That the applicant does not hold or has not applied for a certificate from a specialty board, and that he does not list himself in the American Medical Directory or elsewhere as a specialist in some branch of medicine other than radiology.

4. That at least 75 per cent of the applicant's time is being devoted to radiology.

A Biography of Dr. Benjamin Rush.—The first full biography of Dr. Benjamin Rush, distinguished physician and citizen of the Revolutionary period, is published this month by the University of Pennsylvania Press. The biography is written by Nathan G. Goodman.

The history of early American medicine is largely the record of Rush's life, for he was not only the greatest physician and most influential teacher of medicine in his day, but a pioneer in almost every field of medical science. He was one of the first advocates of preventive medicine, and his ideas on diet, exercise, sanitation, mental health, the connection between decayed teeth and arthritis, were distinctly modern. He was the first American psychiatrist and the first formal professor of chemistry. He wrote the first book on mental diseases, considered a classic for fifty years, and the first chemistry text. He founded the first free dispensary in Philadelphia and the College of Physicians. In noting that mosquitoes were more prevalent during the devastating yellow fever epidemics in 1793 and the years following, he came near to discovering the great secret of contagion. His writings on every phase of medicine would make an appreciable library.

Rush was also an intense patriot and outstanding social reformer. His political activities included cooperation with Thomas Paine in publishing his "Common Sense," service as Physician-General of the Middle Department during the War, aid in drawing up the Declaration of Independence, which bears his signature—the only M. D. on the list—and active promotion of the Constitution in 1787.

His contributions to social advancement included: founding of the first temperance and antislavery societies, first Sunday-school system, and Dickinson College. He also advocated many reforms in public education and penal laws.

CORRESPONDENCE

Subject of the following letter: Reply of Dr. Howard H. Johnston to letter of Pacific Roentgen Club, printed in the November "California and Western Medicine," page 357.

To the Editor:—The article on "Crossroads and Cross Purposes" does not propose changes of any kind in the practice of medicine, or in the practice of radiology, which is a minor specialty in medicine.

The whole subject has been buried under a maze of words. The average doctor wants to see the general public given hospital insurance, in order that his patient may go through a hospital experience without having all his funds taken away by the hospital. The general public is becoming more and more interested in hospital insurance in some form. Establishment of hospital insurance has been blocked by fruitless discussion of positions to be occupied in the scheme by x-ray men, particularly.

Legally, a corporation cannot practice medicine. Therefore, a hospital cannot employ a pathologist or an x-ray man to give medical opinions or treatment, but the hospital *can* establish laboratories and x-ray departments, with their equipment and technicians, in the same manner as it now establishes operating rooms, with their equipment and surgical nurses.

Previous discussions of this matter have been held, as it were, behind closed doors, for the past two years here in San Francisco. With no practical result obtained, the matter is now being introduced to the attention of the rank and file of medical and hospital people, there to be decided, we hope.

If medical men in actual practice would sit down and discuss this matter with level-headed business leaders representing hospital governing boards responsible for many millions of dollars invested in hospitals, a solution of our difficulties would be arrived at in time to unite our forces in a coöperative effort to give the public adequate hospital care at budgetable rates within its income, before the job is taken over by self-seeking politicians, lay or medical, and quasi sociologists.

The plan or method for doing justice to the public and each other is not essential. Justice and fair dealing depend upon individuals, and not plans.

Referring to Doctor Garland's "General Comment," it should be noted that the Cleveland Hospital Council did *not* desire to sell *professional* medical service, as is demonstrated by their delay of two years, awaiting the decision of the Cleveland Academy that *diagnostic x-ray work* should be excluded from hospital service.

Under the close observation of Dr. A. C. Christie, Washington, D. C., this question was decided in *another* manner, *i. e.*, by *ex*cluding *both* professional and technical x-ray work, and *in*cluding routine *technical* labo-

ratory work. Certain leaders in radiology reject this plan.

If x-ray departments were open to qualified radiologists, as Doctor Garland maintains they are, or in the same manner as are surgical operating rooms, we might have several effects: (1) there would be free choice of radiologist; (2) patients in hospitals monopolized by one radiologist on part-time basis would be more likely to receive the service Doctor Garland and the writer agree they should have, *i. e.*, supervision of technicians and examination of patients; and (3) a *natural* monopoly of the x-ray department might develop, to displace the compulsory monopoly which exists today.

The majority of Doctor Garland's objections and criticisms are directed at a part of the x-ray discussion in "Crossroads and Cross Purposes," which is plainly *labeled* "Writer's Opinion," or his speculations as to what might be done if all agreed with the basic decisions arrived at in Cleveland.

Thus Doctor Garland and the writer agree that something did happen in Cleveland, and that what happened is not satisfactory to some radiologists; that although 400 contracts for hospitalization had been sold on September 1, after six weeks' sale, many of the insured were not sick in a hospital. This is fortunate for both the insured and the hospital association.

However, let us have a solution; *any* solution, arrived at in the presence of the parties concerned.

Howard H. Johnston.

210 San Leandro Way, San Francisso.

* * *

[*This was referred to Doctor Garland, who replies:*]

To the Editor:—The analogy between the x-ray department and the surgery as drawn by Doctor Johnson is quite apt; it is to be remembered, however, that while the hospital, in the surgery, provides operating rooms, surgical instruments and nurses, *it does not attempt to use those instruments.* Similarly, it should not attempt to use x-ray instruments by producing roentgenograms. Recognized hospitals allow only surgeons to operate; recognized hospitals allow only roentgenologists to practice roentgenology. To permit or encourage *anyone* to read the films would be to contravene long-standing rules of the American College of Surgeons and the American Medical Association for approved hospitals.

The taking of a biopsy specimen in a surgical examination is as much a medical procedure as the subsequent surgical therapy. The taking of an x-ray film is as much a medical procedure as the interpretation of it.

Doctor Johnston pleads for a solution. He has it. If radiologists (in hospitals where private patients are handled and where all staff members are not on a full-time salary basis) were appointed on a rental basis the problem would be solved instantly. The hospital would be relieved of the onus of practicing medicine and would secure an equitable return on its entire x-ray investment.

L. H. Garland, M. D.,
Secretary, Pacific Roentgen Club.

Subject of following letter: Acknowledgment of letter to Association Secretary on death of Dr. H. D. Lawhead.

Office of State Board of Equalization
State of California
Room 328, Porter Building
Woodland, California

California Medical Association,
San Francisco, California,
F. C. Warnshuis, M. D., Secretary.

My Dear Sir: In acknowledgment of your telegram of November 30, kindly accept the writer's appreciation for the beautiful sentiment expressed and the consoling tribute paid my beloved father, Dr. H. D. Lawhead.

His passing was a great shock; yet, if this had to be, a more beautiful and comforting way could not be asked. In his many years of practice he had seen so much pain, suffering and sorrow, that to be spared all of these in his last moments seems as though a prayer were answered.

Very sincerely yours,
Fred S. Lawhead.

Subject of following letter: Communication from Secretary of State Board of Medical Examiners to Association Secretary.

Board of Medical Examiners
420 State Office Building
Sacramento, California,
November 9, 1934.

Yours of November 3, re: San Quentin inmates.

California Medical Association,
F. C. Warnshuis, M. D., Secretary,
450 Sutter Street,
San Francisco, California.

Dear Doctor Warnshuis: The information regarding the number of M.D.'s and licensed chiropractors now incarcerated in San Quentin Prison has just been received, and shows as follows:

Physicians and Surgeons:

*George E. Darrow, No. 50559—Murder, second degree (illegal operation).

*Mathew J. Marmillion, colored, No. 55160—Murder, second degree (illegal operation).

*Oscar W. De Vaughn, colored, No. 56283—Murder, second degree (illegal operation) and subornation of perjury.

Chiropractors:

Arthur O. Berg, D.C., No. 47159—Murder, second degree (illegal operation).

Guy E. Grosse, D.C., No. 56718—Abortion.

*Joy V. Simmons, D.C., No. 55053—Abortion.

All of those above mentioned who have held licenses issued by the Board of Medical Examiners (indicated by asterisk) have had the same revoked. Joy V. Simmons, D. C., was originally holder of a drugless practitioner's license under the Medical Practice Act, which was revoked. He was also a licensed chiropractor.

I am informed by the Board of Chiropractic Examiners that they have revoked the licenses of Arthur O. Berg, D. C., and Joy V. Simmons, D. C. They report that the Guy E. Grosse, D. C., case will be up for a hearing on November 16, 1934, to show cause why his license should not be revoked.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

Subject of following letter: Thanks of American Red Cross to California and Western Medicine.

Washington, D. C.,
December 1, 1934.

To the Editor:—Please allow me to express to you, in behalf of our national officers, our very sincere appreciation for the generous contribution of space which you gave to the American Red Cross in California and Western Medicine. It is only through the splendid coöperation which you and others give to us each November that we are enabled to extend a universal invitation to all Americans everywhere to participate in Red Cross work through individual memberships.

Cordially yours,
Douglas Griesemer,
Director of Roll Call.

Subject of following letter: On the sale of dinitrophenol.

City and County of San Francisco
Department of Public Health

December 11, 1934.

To the Editor:—We are sending you a copy of a recent order issued after several fatalities that occurred in the Bay area.

On authority from the Director of Public Health.

PAUL S. BARRETT, M.D.,
Acting Assistant Director of Public Health.

* * *

December 7, 1934.

EXECUTIVE ORDER NUMBER NINETY-SIX

The sale of dinitrophenol, or of any proprietary product containing the same, is forbidden within the city and county limits of San Francisco, except on the written prescription of a licensed physician and obtained from a duly registered pharmacist.

J. C. GEIGER, M.D.,
Director of Public Health.

VITAMIN D MILK

Excerpts from a bulletin recently sent out by the Press Service of the Office of Information of the United States Department of Agriculture follow:

Because vitamin D milk is such a convenient form in which to supply this vitamin in the diet of babies and young children, the merits of this product for general use are likely to be overstated, according to Dr. E. M. Nelson, an authority on vitamins in the Bureau of Chemistry and Soils, United States Department of Agriculture. Since its introduction a short time ago, milk fortified with vitamin D by irradiation with ultra-violet rays or by feeding cows irradiated yeast or by the addition of cod-liver oil extract has become popular and many claims have been made for it.

There is no satisfactory clinical evidence to show that adults who get a reasonably good diet need additional vitamin D, says Doctor Nelson. A person who eats an egg a day probably meets all the needs for this vitamin even if he eats no other food which supplies it. We have no reason to question the value of fortified milk for young children where physicians have prescribed some form of this vitamin, says Doctor Nelson, but there will have to be much more research before we will know just how much value it has for general use.

"The practice of increasing vitamin D content of milk has raised many questions which research workers have not yet had time to answer. These questions must be answered before milk dealers and nutritionists can confidently establish the standards for treating milk, which eventually should be required in this branch of the milk business."

So far the greater part of the research work with irradiated foods has been in the laboratory with small animals, and there has not yet been time to check these results carefully in practical feeding tests with children and with adults.

To illustrate the extremely minute quantities of pure vitamin D which are contained in foods that have marked protective and curative action in cases of rickets, Doctor Nelson explains that one-fourth of a gram of the pure vitamin has the protective qualities of thirty gallons of cod-liver oil or ten thousand quarts of fortified milk.

Speaking before the International Association of Milk Dealers recently, Doctor Nelson emphasized that the fortification of milk with vitamin D is a venture into a new field in which milk dealers are made to share a new responsibility. Milk distributors cannot afford to take that responsibility with indifference. In the past their chief concern with health problems has been one of dispensing a natural product which is free from disease-producing organisms. If they alter the product to increase its nutritive value, even to the extent of preventing disease, their obligation to milk consumers assumes a different aspect. "If the manufacture of vitamin D milk is going to be of greatest value to your industry and to the milk consumer, it behooves your association to make a careful survey of the proper place of fortified milk in our dietaries and to set a goal for which you should strive. Do not permit the lure of immediate profits to place you at a possible disadvantage at some future time."

Doctor Nelson said that there were several definite questions on which science was not yet able to speak confidently. It has not been established whether vitamin D milk has a logical place in the dietary of children beyond the age at which rickets occurs, or whether adults need the fortified milk. Science has practically no information as to the vitamin D requirements of adults and older children; does not know how much vitamin D can be stored in the body; does not know the extent to which sunshine contributes vitamin D; does not know the vitamin D content of many natural foods. There are also many foods other than milk which have been fortified with vitamin D and which enter into otherwise normal diets for persons older than children who are subject to rickets. The speaker summarized some of the information available along these lines and said it is probable that adults require less vitamin D daily than would be supplied by a half teaspoonful of cod-liver oil, although women may require more in pregnancy and lactation. There is no evidence, he said, that a significant proportion of the adult population suffers from vitamin D deficiency. Eggs and fish, such as salmon, sardines, and herring, contain considerable vitamin D.

Doctor Nelson, who recently returned from an international conference held in London on standards for measuring vitamin units, explained to the convention the laboratory methods for assaying the vitamin D potency of fortified milk in comparison with the standards of measurement, which depend on the curative action of vitamin D in checking the development of rickets in white rats and in promoting a measurable degree of cure in animals maintained on a rigidly regulated and uniform diet which causes rickets unless checked by the vitamin D in the foods under test.

This and That

Need for Organization.—The most urgent and imperative local need of the day is an organized medicine deserving its name in fact. The objectionable separation of our doctors in different groups or associations, which inevitably leads to self-contradiction, misunderstanding, and even self-destruction professionally, must immediately cease. The social phenomena that actually surround our common life and country requires more than mere sporadic, fragmented and disconcerted medical aids and action. Our necessity to link ever more closely our medical interests and capabilities to our national economic plan of readjustment is only feasible through a strong united federated medical organization as a prerequisite to government recognition and confidence.—Editorial, *Journal of the Philippine Islands Medical Association,* October, 1934.

* * *

Medical Societies.—"I have never quite understood why so many men do not belong to their county and state medical societies. I have questioned such men sometimes. They usually say that they do not find the societies of much value. But they could help to make them valuable. They say they can get the same information from books and journals. But individuals who seek isolation soon find it is not necessary to take good journals and books. They begin to rely on cheap medical journals which advertise certain remedies which it is hoped will take the place of medical consultations. After a time you will find that dust gathers on these journals—unopened."—W. J. Mayo, in *Staff Proceedings,* January 17, 1934.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 1, January, 1910

From Some Editorial Notes:

To County Secretaries.—This year it is particularly important that all reports of membership should be sent to the secretary of the State Society as early in January as possible—and more important that they should be accurate. The medical defense feature of the State Society is extended only to those members who have their dues fully paid up, and therefore are in good standing in their county society. If a member is delinquent for three or four months, he is not in good standing during that period of time, and should any act of his during that period result in a subsequent suit for malpractice it could not be defended by the State Society. . . .

* * *

You Can Help Us.—You can help the State Society and your *Journal,* and therefore incidentally help yourself, by taking an active interest in the advertising pages of the *Journal.* Look over the advertisements each month; see what is newly offered; use the advertising pages as a sort of directory for firms from whom you buy things or for sanatoriums to which to send patients. Other things being equal, make your purchases from those firms who help to support your *Journal* by advertising in its pages—and let them know that you do so. . . .

* * *

Experiments on Animals.—The "antivivisectionist" may possibly draw awful pictures of frightful dog agony and human brutality, etc., etc., from an article which appears in this issue from the pen of Doctor Bunnell, and based upon research work done by him in the laboratory of Doctor Crile. Never was a more clear-cut example of the value to humanity of animal experimentation. . . .

* * *

The Treatment of Wounds.—In the report of the Twenty-first Congress of French Surgeons, Dupuy of Paris publishes an interesting account of his experiences with the electric light in the treatment of large wound surfaces which have proved rebellious to other methods. He induces hyperemia by employing a thirty-candle-power lamp placed ten centimeters from the wound. . . .

From an article on "The Problem Presented by the Tuberculous Railway Employee" by Robert A. Peers, M.D., Colfax.

I do not know when or where the first hospital association for the care of sick and injured railway employees was formed, nor is it relevant to the subject-matter of the paper I have to present to you this afternoon. It is, however, pertinent to say that today practically every corporation, railways, steamship companies, steel plants, mining and lumbering companies, has established for the care of its sick and injured a hospital or benefit association whereby each member, for a certain stated monthly sum subtracted from the wages by the corporation, is guaranteed in case of illness or injury the necessary nursing and medical attention with accommodation in the hospitals of the company, without further expense. . . .

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, Page 14)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

"Dr. Mae Wilson, woman physician, yesterday was acquitted of second degree murder, growing out of the death of 22-year-old Lucille Gooden over an asserted illegal operation. Superior Judge Desmond dismissed the case on the grounds of insufficient evidence." (Los Angeles *Times,* December 6, 1934.)

"Health officials join physicians today in a campaign against fat-reducing remedies, following the death of three-year-old Edward Moore, 219 Kelsey Street, Richmond, who mistook some pills for candy. . . . Federal Pure Food and Drug officials here were also expected to enter the investigation. The young boy was literally 'burned to death' after taking the compound, hospital authorities reported. Other victims have been reported during the last few months. Last year Dr. Hans Gessner was a victim." (San Francisco *Call-Bulletin,* December 6, 1934.)

"In Fort Payne, Alabama, several weeks since, an eight-year-old son of parents who belong to a faith-healing cult, developed an infection of the leg and was near death. The parents steadfastly refused to allow the boy to be removed to a hospital for treatment, but under threat of prosecution grudgingly allowed a physician to come to the home and scrape several inches of the bone in the infected area. While the doctor worked over the boy with the aid of an oil lamp, members of the cult kept up a constant chant in a strange tongue. Now the boy is improving and is able to walk, although with a pronounced limp. The physicians say he will recover completely in time. With his cure assured, members of the cult take full credit for it, holding that by their efforts the evil spirits were chased from the boy's leg. Since the boy is well, it will make little difference who gets the credit, but the average person will prefer to have the spirits chased out of his body with the aid of a competent physician. Moreover, any parent believing in faith healing who withholds medical aid to children, should be prosecuted." (Sacramento *Bee,* December 4, 1934.)

"Holding that the evidence introduced before the State Board of Medical Examiners did not warrant the revocation of the license of George W. Fuller to practice medicine and surgery, Superior Judge Wilson has modified the judgment so as to carry a reprimand instead of loss of license. The court made its ruling after finding that there was sufficient evidence that the doctor had violated the Medical Practice Act through issuing of a pamphlet relating to non-operative treatment of hernia. . . ." (Los Angeles *Times,* December 10, 1934.)

"As far as the income tax was concerned, Dr. J. L. Lovell, physician (chiropractor), could not quite understand. Yesterday, after explaining he had no intention of evading payment of $2,274 in income tax, Lovell was fined $500 and given a suspended sentence of six months in jail. . . ." (Los Angeles *Illustrated Daily News,* December 4, 1934.)

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, Page 16)

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May color if desired.
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Highly bactericidal and deoderant.

The suggested prescriptions which follow represent two highly detailed and overpriced proprietaries:

Codein Phosphate	gr.	2	.14
Spirits Chloroform	m.	11	.7
Potassium Guaicol Sulphonate Ammonium Chlorid aa	gr.	16	1.
Antimony et Potassium Tartrate	gr.	⅙	.01
Syrup Wild Cherry or Syrup Yerba Santa Aromatic qs	oz.	2	60.

Sig. Ten drops to one teaspoonful as required.

Codein Phosphate	gr.	2	.14
Calcium Bromid	gr.	16	1.
Spirits Chloroform, Tincture Belladonna	m.	20	1.3
Syrup Wild Cherry qs	oz.	2	60.

Sig. Ten drops to one teaspoonful as required.

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Elixir Viburni Opuli Compositum
Elix. Viburn. Opul. Co.

Fluidextract Viburnum Opulus	7.5 c.c.
Fluidextract Trillium	15.0 c.c.
Fluidextract Aletris	7.5 c.c.
Compound Elixir Taraxacum (sufficient quantity)	
	100.0 c.c.

Elixir Viburni Prunifolii
Elix. Viburn. Prun.

Fluidextract Viburnum Prunifolium	12.5 c.c.
Compound Tincture Cardamon	7.5 c.c.
Aromatic Elixir qs	
	100.0 c.c.

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Viburnum Opulus	3.5 gm.
Dioscorea	3.5 gm.
Scutellaria	1.0 gm.
Clove	5.0 gm.
Cinnamon	6.5 gm.
Glycerin	7.5 c.c.
Alcohol, water, each, qs	
	100.0 c.c.

The Viburnum Mixtures are best used teaspoonful doses in hot sweetened water as indicated.

Cinchophen and Amidopyrin Dangerous to Health and Life, Says Food and Drugs Chief.—Widespread use of two dangerous drugs—one which destroys the liver and the other which kills the white corpuscles—brought a warning today from the Federal Food and Drugs Administration. These drugs are cinchophen and amidopyrin. Cinchophen, a chemical anodyne and sedative, is sometimes used by sufferers from neuralgia, rheumatic pains, neuritis and similar conditions. Amidopyrin is frequently found in headache remedies and other pain killers.

"Current medical literature contains many reports which clearly indicate that these drugs are dangerous to health and life," says W. G. Campbell, Chief of the Food and Drugs Administration. "The gradual development of serious poisoning from the use of these drugs is often so insidious that the danger is not recognized by the user. Cinchophen causes a degeneration of the liver cells. Amidopyrin may cause a reduction in the number of white blood cells, a condition called agranulocytosis."



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In issuing the warning, Mr. Campbell made it plain that he was not implying that all headache and rheumatism remedies contained these dangerous drugs. But the fact that some of them do is sufficient reason for the public to be careful. Several manufacturers declare on their labels the presence of these drugs in their medicines, but others do not. There is no provision in the Food and Drugs Act to compel manufacturers to declare either of these drugs.

The Federal Food and Drugs Act requires manufacturers to declare upon the labels of their products the presence of several narcotic drugs. When the law was passed cinchophen was unknown and the dangerous effects of amidopyrin had not been recognized. For these reasons these drugs were not included in the list.

Under present conditions buyers should observe two precautions, says Campbell. First, read the label and look for statements of the presence of these drugs. If they are not declared and there is any doubt, ask the druggist or write to the Food and Drugs Administration in Washington and ask for the facts.

Sanitation at State Fair Grounds.—In accordance with a long-established custom, the Bureau of Sanitary Inspections of the State Department of Public Health supervised the maintenance of sanitation at the State Fair held in Sacramento, September 2-9. Particular attention was paid to sanitary features related to the serving of foods and beverages. All food-supply places and soft-drink stands were inspected at least three times daily. All soft drinks were kept in closed containers, and those which were held in bulk were drawn through faucets into paper cups. Wherever glassware was used, proper methods of sterilization were employed. Rest-rooms and toilets were maintained in clean condition. Waste matter, including garbage, was removed regularly and garbage containers were kept in clean and sanitary condition.

Mr. Charles Paine, secretary and manager of the State Agricultural Association, provided full coöperation, together with concessionaires, in maintaining sanitary conditions throughout the buildings and grounds during the time that the Fair was in progress.

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The Nutritional Value of Cheese.—Cheese, like milk, is a dairy product of unique value in the diets of children and adults.

There are, according to Crumbine and Tobey (*The Most Nearly Perfect Food,* page 185, 1929), more than four hundred varieties of cheese, although only about twenty different kinds, which may be divided roughly into the hard and soft cheeses. In the former class are Cheddar, Swiss, Edam, Roquefort, etc., while the latter includes cream, Brie, Camembert, Limburger, etc.

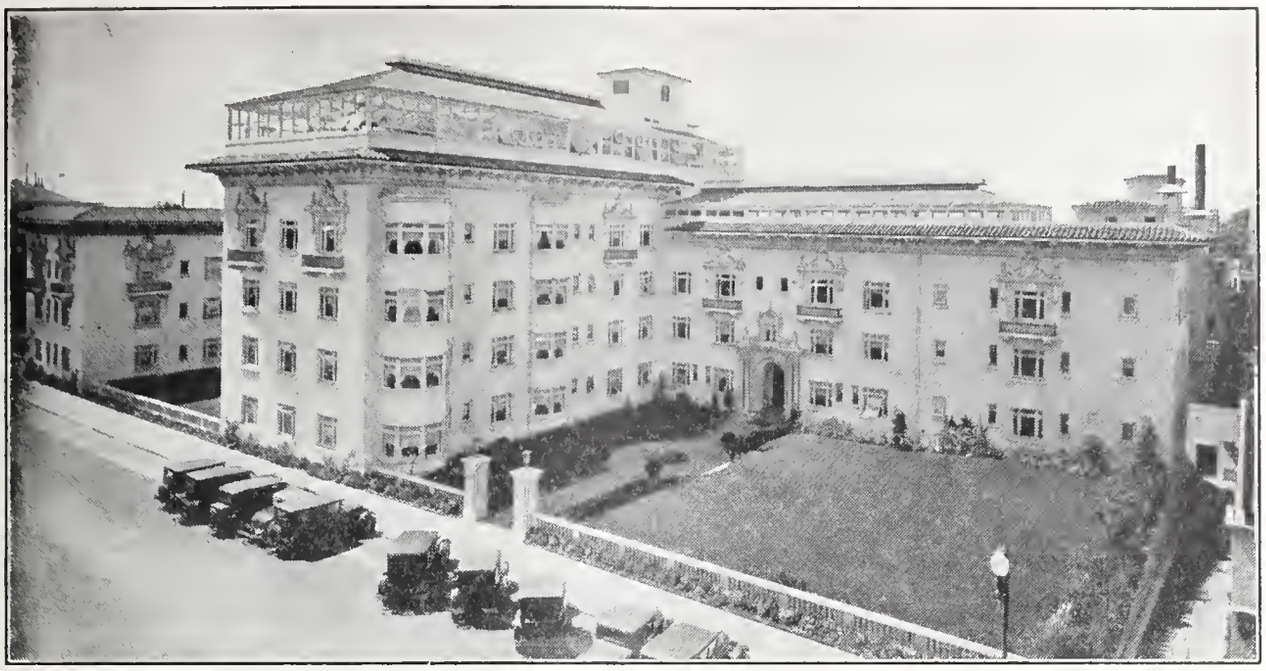
Although the composition varies, many cheeses have about one-third water, one-third fat, and one-fourth protein. The most common cheese, American Cheddar, averages 36 per cent water, 34 per cent fat, 24 per cent protein, and 3.6 per cent minerals. It yields 410 calories per 100 grams, or 1,860 to the pound.

Since cheese is rich in butterfat, it is an excellent source of vitamin A, a fact which has been demonstrated experimentally by Morgan (*American Journal of Physiology,* 78:11, September, 1926), who reports, however, that American Cheddar and Limburger are better sources of this vitamin than is imported Swiss cheese.

The protein of cheese consists mainly of the digested casein and to a less extent of the albumin of the milk, the high nutritive values of both of which are generally recognized. Sherman (*Food Products,* 1933), points out that a pound of cheese represents the casein and fat of a gallon of average whole milk.

Cheese is an excellent source of the indispensable minerals, calcium and phosphorus, although rennet-curd cheeses are much higher in these minerals than are those prepared from soured milk. Thus, Cheddar cheese has been shown by Blunt and Sumner (*Journal of Home Economics,* 20:587, 1928), to have 0.71 per cent calcium, whereas cottage cheese has only about 0.08 per cent. Tests by McCammon, Caulfield, and Kramer (*Journal of Dairy Science,* 16:253, May, 1933), indicate that the hard cheeses retain about 80 per cent of the calcium of the milk, and the soft cheeses about 20 per cent.

That the calcium of cheese is as well utilized as is that from milk has been demonstrated by Mallon, Johnson, and Darby (*Journal of Nutrition,* 5:121, March,



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1932), who compared American Cheddar with pasteurized whole milk by means of metabolism tests on human adults.

"Without milk or cheese in the diet," says Bernheim (*Journal of the American Medical Association,* 100:1001, April 1, 1933), "it is difficult to obtain the needed calcium through food alone."

Contrary to much erroneous opinion, cheese is not difficult to digest. As pointed out editorially in the *Journal of the American Medical Association* (98:1657, May 7, 1932), "Many experiments undertaken in Government laboratories have indicated the excellent utilization of cheese even when it is eaten in liberal amounts."

The Borden Company manufactures many kinds of cheese. Included in these quality products are Borden's American, Pimento, Swiss, Brick, Limburger, Buffet, and Cream cheeses; Military Brand Camembert, Brie, and Swiss Gruyere; Napoleon Brand Roquefort; Liederkranz; Chateau; Lakeshire; Anona; and Grated American and Italian cheeses.

Deaths from Cerebral Hemorrhage and Apoplexy.—Since 1930 the death rate for cerebral hemorrhage and apoplexy has shown a decrease each year. In 1933 the death rate for this disease was 74.0 per hundred thousand population, which is the lowest rate for this cause that has been recorded in California since 1917. The highest death rate for cerebral hemorrhage and apoplexy was in 1924, when the rate was 102.0 per hundred thousand population. As a rule, the variation in the rates for this disease are not conspicuous. The factors that have caused the maintenance of lower rates during recent years are unknown. Whether the change in methods of living due to changed economic conditions has produced lower death rates for apoplexy is not known. It is reasonable to suppose, however, that the elimination of high pressure living since

(Continued on Next Page)

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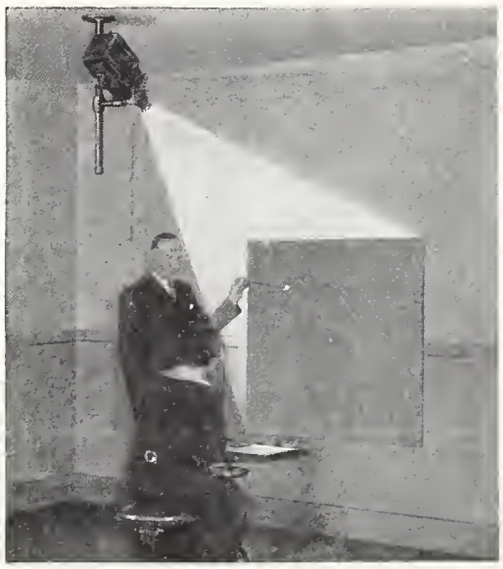
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(Continued from Preceding Page)

the big days of prosperity may have something to do with the improved conditions in mortality from this cause.

The following table gives the number of deaths from cerebral hemorrhage and apoplexy together with rates per hundred thousand population for the years 1906 to 1933:

CEREBRAL HEMORRHAGE AND APOPLEXY

Year	*Number*	*Rate per 100,000*
1906	1,097	53.9
1907	1,143	53.8
1908	1,112	50.2
1909	1,194	51.8
1910	1,379	57.4
1911	1,588	63.3
1912	1,587	60.6
1913	1,965	72.1
1914	1,956	69.0
1915	1,875	63.8
1916	1,533	50.3
1917	2,181	69.1
1918	2,843	87.1
1919	2,801	83.0
1920	3,285	92.9
1921	3,567	95.0
1922	3,877	97.5
1923	4,124	98.3
1924	4,499	102.0
1925	4,357	94.1
1926	4,050	83.5
1927	4.036	79.6
1928	4,549	86.0
1929	4,411	80.1
1930	4,688	81.8
1931	4,445	76.0
1932	4,456	74.9
1933	4,485	74.0

Malpractice Footfalls.—One would hardly think that a woman would bring suit against a doctor because she felt she should have been delivered by cesarean section because her labor was protracted, yet such suit was recently filed.

In the use of a therapeutic lamp one would think that a sunburn would be the worst that could happen but recently a celluloid comb caught fire and severe burns and loss of hair occurred. Caution: Be personally sure all combs and pins are removed.

When engaged for obstetrical care and you are away, it is your responsibility to arrange for attendance.

Be guarded to whom you make reports of physical condition. Recently a doctor made a report to a factory nurse. The man lost his job. He sued the doctor and obtained a judgment for libel.

Instructions given to a minor will not protect you from responsibilities or a suit.

Hospital counts of a sponge is no defense. The surgeon must know all sponges are accounted for.

These are but a few of the legal liabilities that confront a doctor. They indicate the need for extreme care in these days when suits are started on meager provocation.

Food Law Spotlight Hits Poison Used in Sprays to Combat Insect Pests.—Nearly one-third of the time, money, and effort expended by the Federal Food and Drug Administration is being devoted to protecting the public from the danger of poisons used in sprays to combat insect pests and diseases that attack fruits and vegetables. This is revealed by W. G. Campbell, chief of the administration, in his report to Secretary of Agriculture Wallace, which covers the fiscal year ending June 30, 1934. . . . —Press Bulletin, United States Department of Agriculture.

Intoxicating Candy Stopped.—One form of food protection involving public health was the campaign against chocolate confections filled with alcoholic liquors containing from 5 to 20 per cent of alcohol. The sale of such candy is a violation of the Food and

Drugs Act and this requirement was not repealed by the repeal of the Eighteenth Amendment. Chicago, Jersey City, and New York City were the points from which distribution was made. In the East the traffic was carried on with the secretiveness of bootlegging operations. In the Central West distributors were more open, apparently believing that prohibition repeal had nullified the prohibition against alcoholic candies. There was wide distribution in the neighborhood of public schools. Newspapers reported intoxication among school children, resulting from the consumption of these candies. . . .—Press Bulletin, United States Department of Agriculture.

BIRTHS, DEATHS AND MARRIAGES IN CALIFORNIA

Year	Births		Deaths		Marriages	
	Number	Rate	Number	Rate	Number	Rate
1906	20,974	10.3	29,303	14.4	21,317	10.5
1907	24,674	11.6	31,095	14.6	23,005	10.8
1908	28,077	12.7	31,287	14.1	21,739	9.8
1909	30,882	13.4	30,985	13.4	22,917	9.9
1910	32,138	13.4	32,398	13.5	24,937	10.4
1911	34,828	13.9	34,012	13.6	27,303	10.9
1912	39,330	15.0	36,709	14.0	31,276	12.0
1913	43,852	16.1	38,599	14.2	31,393	11.5
1914	46,012	16.2	37,537	13.3	31,902	11.3
1915	48,075	16.3	39,026	13.3	31,451	10.7
1916	50,638	16.5	39,860	13.1	30,996	10.2
1917	52,230	16.5	42,084	13.3	36,283	11.5
1918	55,922	17.1	57,683	17.7	32,487	10.0
1919	56,521	16.8	45,991	13.6	38,830	11.5
1920	67,198	19.0	47,124	13.3	46,564	13.2
1921	72,438	19.3	47,379	12.6	46,972	12.5
1922	73,321	18.4	51,968	13.1	47,477	11.9
1923	80,237	19.1	54,416	13.0	55,190	13.2
1924	86,899	19.7	56,751	12.8	55,677	12.6
1925	85,492	18.5	56,707	12.2	55,081	11.9
1926	82,372	17.0	58,472	12.1	56,664	11.7
1927	84,334	16.6	61,430	12.1	53,487	10.5
1928	83,643	15.8	66,249	12.5	46,945	8.9
1929	81,498	14.8	65,363	11.9	51,866	9.4
1930	84,382	14.7	66,178	11.5	50,154	8.7
1931	81,553	13.9	67,513	11.5	47,525	8.1
1932	78,108	13.1	67,622	11.3	43,164	7.3
1933	75,229	12.4	67,992	11.2	46,484	7.6

Ferric Chlorid for Poison Oak.—The uses of many different products, as well as immunization, have been recommended in the prevention and treatment of poisoning by poison oak. Perhaps the most effective way to prevent this type of poisoning is through immunization, but certain chemicals are also effective. Reference was made in a recent issue of this publication to the value that lies in the application of hyposulphite of soda, which is used extensively in the Ninth Corps Area of the United States Army. It is probable, however, that one of the best products in the prevention and treatment of poisoning from poison oak is tincture of ferric chlorid.

James B. McNair, who has devoted many years of research to problems associated with poisoning from poison oak, discovered the value of ferric chlorid as a remedy and also as a prophylactic. He states that a mixture of half grain alcohol and half water, containing five grams of ferric chlorid per 100 cubic centimeters of the mixture (three level teaspoons to one cup), when allowed to dry on the human skin, will act as a prophylactic. It is said that this will prevent poisoning of the most highly susceptible individual. It is recommended that exposed parts of the body—hands, face and neck—be washed with this ferric chlorid solution before exposure. Individuals who have not been so treated and who contract the poisoning may obtain considerable relief through the same procedure.

Major Thomas R. Marshall, of the Medical Corps of the United States Army, has found that the ferric chlorid treatment is specific and should be used in all stages of irritation. Of course, the earlier the application is made the better the results obtained.

Even in the populous districts, the practice of medicine is a lonely road which winds uphill all the way, and a man may easily go astray and never reach the delectable mountains unless he early finds those shepherd guides of whom Bunyan tells—Knowledge, Experience, Watchful, and Sincere.—Osler.

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GHOST WRITING—SAN FRANCISCO EDITOR AND writer will edit articles for publication, collaborate, act as ghost-writer, or otherwise assist professional persons who may have articles, case histories, etc., speeches to prepare, and no time to do it. Familiar with medical terminology. Wide experience. Confidential service. Elsa Gidlow, 150 Joice Street, San Francisco. Telephone EXbrook 0290.

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Vitamin Advertising and the Mead Johnson Policy. The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

Hospitalization of the Mentally Ill.—Members of the House of Delegates and others have been solicited by Dr. John M. Grimes to purchase a book that he has printed purporting to contain the results of the study recently made by the Council on Medical Education and Hospitals of the hospitalization of the mentally ill in the United States. Such individual use of the Council's material is, of course, wholly unauthorized. A report prepared by Doctor Grimes when he was employed by the association was not published because in the opinion of the Council and an advisory committee of psychiatrists and neurologists his conclusions were not supported by the evidence presented. Two partial reports that have already been published will be supplemented when further studies have been completed.—Reprinted from the *Journal of the American Medical Association* November 10, 1934, Volume 103, page 1457.

Vitamin Supplements to the Diet.—A food product is available containing sufficient vitamin D so that it is unnecessary to go to the expense of buying vitamin D preparations to supplement the diet. For, according to clinical tests, Cocomalt, when taken three times a day, will supply children with enough vitamin D. Cocomalt contains not less than 30 Steenbock (81 U. S. P. revised) units per ounce—the amount used to make one drink. Cocomalt is licensed by the Wisconsin University Alumni Research Foundation. Ordinarily vitamin D preparations are unpalatable, but in this form its existence is unsuspected.

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An interesting booklet about the origin and function of all the accepted vitamins has been prepared by R. B. Davis Company, the makers of Cocomalt. It may be secured on request without cost by writing the company at Hoboken, New Jersey.

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It's partly because you and he became such good pals when you pulled him through that siege last summer.

But more than that, he had heard his Dad and me talking, and he knew that this was different from the ordinary check we send out—that it deserved something more than the slapping on of a stamp and routine delivery by the mail man.

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You couldn't have done more if he had been your own child. We've always known this, and yet your bill has lain here, put off month after month, while bills for other things have been paid.

It wasn't that we didn't want to pay you, for we did. But after we bought those things necessary to keep us going—food, and clothing, and coal—our bank balance was pitiful to behold.

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BOOK REVIEWS

(Continued from Page 11)

use of somewhat larger amounts of spinal fluid and maintenance of a horizontal position has put less strain on the heart.

The author discusses procain (novocain) only, and except for a short paragraph on nupercain, makes no mention of drugs with a more lasting anesthetic effect, such as pantocain, etc.

The work will repay close study and repeated reference.

L. E.

The White-Headed Eagle: John McLoughlin, Builder of an Empire. By Richard G. Montgomery. Pp. xiii, 358. New York: The Macmillan Company, 1934. Price, $3.50.

Well worthy of critical study, such as that recently given by the gifted Dr. George D. Lyman to the absorbing life story of Dr. John Marsh, this thrilling biography by an informed Portland bookman, of one of the heroic figures of the early West, a poor young Canadian who attained the distinction of "Father of Oregon," is sure to direct attention anew to the inestimable contributions again and again made by pioneer medical men toward the advancement of civilization. Born in 1784, in a crude farmhouse about 120 miles from Quebec, John McLoughlin, while yet in his middle teens, chose the field of medicine; but whether he earned his degree in a medical school or simply learned "doctoring" from some kindly old country practioner, "he became such a resourceful physician, a skillful surgeon, and a man of both noble and compassionate character," that it is no wonder he made himself famous as a pathbreaker for the many thousands who followed after him. "The man to set a broken leg," as Mr. Montgomery says, "amputate a foot, or apply a timely dose of physic, and then weep unabashed for the poor heathen who writhed in pain before him," McLoughlin, coming West (where he was hailed by the Indians, who loved him for his kindness and deep sense of justice, as the "White-Headed Eagle"), entered the employ of the Northwest Company, the Hudson Bay Company's rival; married an Indian half-breed of remarkable character; worked for the union of the two warring companies; became the chief factor of the Hudson Bay Company in the vast Columbia River region, and founded the trading post at Vancouver, where for years he ruled like a king, only to be swept from his throne by the invading hordes of ambitious and avaricious easterners determined also to have a share in the promising land he had first spied out, and to close his eyes for the last time, in 1857, to a world no longer offering him inspiration, joy or consolation. The father-in-law of William Glen Rae, founder of the Hudson Bay settlement at Yerba Buena, Doctor McLoughlin in 1841 visited California, his experience of moving away from home quickening his desire to assist needy pioneers, most of whom broke their promises and never repaid him for gifts and disbursements made to relieve their distress.

In addition to some illuminating illustrations, the author has properly added a creditable bibliography and also an appendix of scholarly notes; and there is a fairly comprehensive index, unfortunately, however, incomplete. The death of the subject, for example, is not listed. The "Mr. Hale of the United States Exploring Expedition" is, of course, Horatio Hale, the philologist. And one might expect to find indexed William Cogswell (here incorrectly given as Coggswell), the painter of Lincoln and Grant, whose portrait of McLoughlin serves as the frontispiece, and Edwin Markham, the poet and author of "The Man with the Hoe," who, as a native of Oregon, pays the White-Headed Eagle a touching tribute, saying: "He deserves the glory of an eternal memory, as one of the towering personalities of the Far West. After eighty battling years"—Markham was five years old when McLoughlin died—"I still remember this consecrated son of humanity. I was taken into the cathedral in Oregon City, where he was lying in state, and it seems only yesterday when some strong man lifted me onto his shoulder to look down upon the face of the great dead—my first encounter with death."

TWENTY-FIVE YEARS AGO

(Continued from Text Page 144)

From an article on "Cesarean Section with Report of Nine Cases" by Alfred Baker Spalding, M. D., San Francisco.

Although many leading obstetricians have sounded warnings lest we forget those time-honored and supposedly more conservative obstetrical procedures that have served women for generations in their hour of difficult labor, the spirit of surgical aggressiveness of the past twenty years has carried all before it, so that at the present moment it is difficult to discuss accurately the relative value of the operation of cesarean section, on the one hand, and the operations of high forceps, version, pubiotomy and induction of premature labor on the other. . . .

From an article on "Gunshot Wound of the Heart with Recovery" by C. J. Teass, M. D., Kennett.

The first successful operation for relief following a gunshot wound of the heart was performed in 1897 by A. G. Podres, who on the second day made a skin and bone flap containing the left lower portion of the sternum as well as the cartilages of the third, fourth, fifth, and sixth ribs, and having a lateral base. . . .

From an article on "Some Phases in the Handling of Tuberculous Patients" by George H. Evans, M. D., San Francisco.

So much is constantly being contributed to the rapidly accumulating mass of tuberculosis literature that it would seem an act of supererogation to add anything to this subject were it not for the fact that, paradoxical though it may be, the enormous mass of this literature and the great diversity of opinion therein contained have served to confuse the medical mind. . . .

From an article on "The Present Status of the Osmic Acid Treatment of Neuralgia" by T. C. McCleave, M. D., Berkeley.

Two years ago I reported before this Society a case of trigeminal neuralgia treated by intraneural injections of osmic acid. . . .

From an article on "Comments on Tropical Medicine" by Creighton Wellman, Oakland.

Zoölogy and Medicine.—Medical Zoölogy is rapidly coming to its own. Since the recognition of specific causes of disease bacteriology was the first to ally itself with clinical medicine and for a time threatened to divide the field with the pathologist. But there has been and still is an increasingly significant tendency to admit and study the effects of animal organisms in disease with the same thoroughness with which bacterial affections are observed. A considerable part of this is to be credited to students of tropical medicine. . . .

Sonoma County—Regular meeting, Petaluma, January 7, 1910.

1. Address, President S. Z. Peoples, "The Plans and Aspirations of Our Society for 1910." . . . That if our Society accomplished nothing more than getting its members better acquainted, it would serve a useful purpose. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 144)

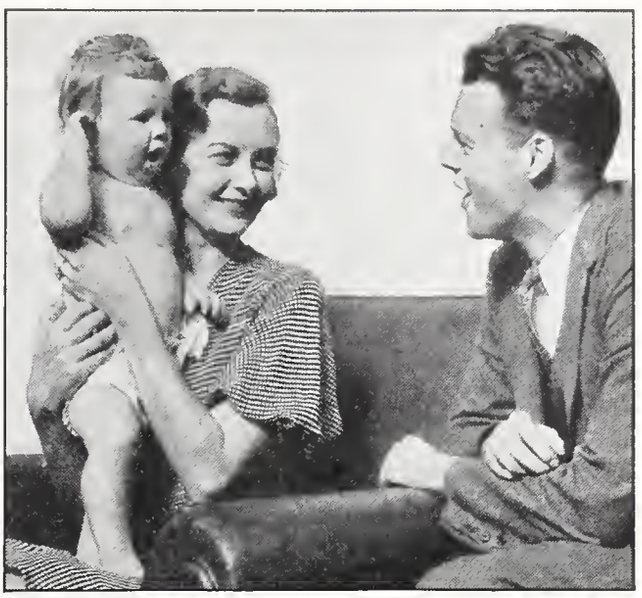
1935, in the municipal court of the city of Los Angeles, sentenced to pay a fine of $600 or serve 180 days in the city jail.

Found guilty of violation of Section 15 of the Chiropractic Act, George Shabo was sentenced to pay a fine of $50 or serve twenty-five days in the city jail, sentence being suspended and defendant placed on probation.

On December 3, 1934, the Appellate Department of the Superior Court of Los Angeles affirmed the judgment of the lower court rendered July 19, finding Aris Amaral guilty. On January 9, 1935, his plea for probation was denied. He was sentenced to 180 days in the city jail.

Maria Dominguez, charged with violation of the Medical Practice Act, was reported convicted on a charge of second degree murder and thereafter sen-

(Continued on Next Page)



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THEY'RE a healthy, happy young couple—proud in the possession of their first baby.

Though they are average people in average circumstances, they are as sure as anyone reasonably can be that their little one will develop normally — grow tall, straight and strong — have firm, sound teeth and bones.

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Cocomalt comes in powder form, easy to mix with milk — HOT or COLD. Sold at grocery and drug stores in ½-lb. and 1-lb. air-tight cans. Also in 5-lb. cans for professional or hospital use, at a special price.



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An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

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Tumor Pathology
A. H. WARNER, Ph. D.,
Physicist

BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

tenced to serve five years to life imprisonment at the Woman's Prison at Tehachapi.

William E. Charlesworth, charged with violation of the Medical Practice Act, was reported sentenced in municipal court of Los Angeles, February 6, 1935, to serve six months in the city jail, sentence being suspended and defendant placed on probation for five years.

Fred Besuzzi, charged in the justice court at Alhambra with violation of the Medical Practice Act, was reported sentenced December 28 to pay a fine of $100. It is alleged that he claims to have posted $1,000 as a guarantee that his diagnoses are correct; however, his claims could not be substantiated.

"The 'Capper and Steerer' section of the State Medical Practice Act, which prohibits physicians from soliciting business through hired agents, is constitutional in the belief of Attorney-General U. S. Webb. 'There are sound reasons on which to base the distinction between the physician on the one hand and the manufacturer or merchant who solicits trade through hired agents,' said Mr. Webb in an opinion to Charles B. Pinkham, secretary of the State Board of Medical Examiners." (San Francisco *News*, January 7, 1935.)

"At the door of the county jail when he was released today, following his acquittal on a murder charge, Paul de Gaston, Hollywood medical student, was taken into custody on a charge of practicing

medicine without a license. De Gaston had been accused of performing an illegal operation on Mrs. Irene Eillert, resulting in her death. . . ." (Los Angeles *Evening Post,* December 31, 1934.)

"Dennis B. Imlay, thirty-five, a chiropractor, formerly of Salinas, who was sentenced to fifteen months in the federal penitentiary on his plea of guilty to violation of the Dyer Act last July, today is being held in the county jail pending expected removal to McNeil Island. The accused doctor admitted, according to Morris Akers, Department of Justice agent, he had stolen a car at Salinas and driven it to Reno, Nevada, where he sold it for $125" (San Francisco *Call-Bulletin,* January 7, 1935). The Board of Chiropractic Examiners report their records show no individual by this name licensed.

"Jailed on charges of violating the State Narcotic Act, Dr. Walter F. Pike, fifty-seven, Oakland physician, was released from the Oakland city prison on bail today after his arrest. . . . Doctor Pike, said by the officers to have purchased 1,400 morphine tablets in the past year with no record to show their disposition, posted $2,000 bail. . . . Doctor Pike was arrested in 1931 on a narcotics charge . . . but was found not guilty." (San Francisco *Call-Bulletin,* January 5, 1935.)

"Dr. Burton H. Pelton, sixty-nine, of 409 Acacia Street, Compton, headed a list of six persons facing charges of violation of the State Poison Act this week. . . . Doctor Pelton, Compton practitioner for more than eleven years, was said to have had morphin valued at $4,000 in his possession. According to police, he accepted $10 in marked money for eighteen morphin tablets. The physician denied guilt and declared he had issued a prescription to a diseased and registered drug user from San Francisco. Police said the doctor's records show he had bought $17,000 worth of morphin since last December 31" (Huntington Park *Bulletin,* December 21, 1934). A citation has been issued calling Doctor Pelton before the Board of Medical Examiners at the February meeting.

"District Attorney C. A. Walker yesterday dismissed a complaint accusing Dr. Robert E. Haslett, Chico chiropractor, of performing an illegal operation. Dr. Haslett was arrested November 13 by J. W. Davidson, State Investigator, on a complaint sworn to by Mrs. Josephine Cudley of Orland, mother of Mrs. Mildred Stoddard, twenty-eight, upon whom Dr. Haslett was accused of performing the operation. . . ." (Chico *Record,* December 22, 1934.)

"Found guilty of second degree murder in connection with an illegal operation, Harry B. Knowles, self-styled technician, will be sentenced by Superior Judge Fred V. Wood in Oakland today. Knowles was held responsible for the death of Agnatha Bodholdt, 5732 East Fourteenth Street, Oakland. The crime carries a penalty of from five years to life." (San Francisco *Examiner,* December 17, 1934.)

"Taken into custody in a transient camp at San Francisco, where he has been employed as a physician, Charles E. Baker, fifty-seven, who assertedly defrauded several Hemet business men with forged and fictitious checks during a period of service in a Civilian Conservation Corps camp in the mountains near Anza, was returned to the Riverside County jail today to face felony charges. . . . The charges were signed by two defrauded business men . . ." (Riverside *Enter-*

(Continued on Next Page)



When Steers Had Long Horns

THE medicinal value of the glands of internal secretion was not recognized.

But times have changed, as well as cattle. Now, the therapeutic value of certain gland products is definitely established and each year adds to our knowledge in this important field of therapeutics.

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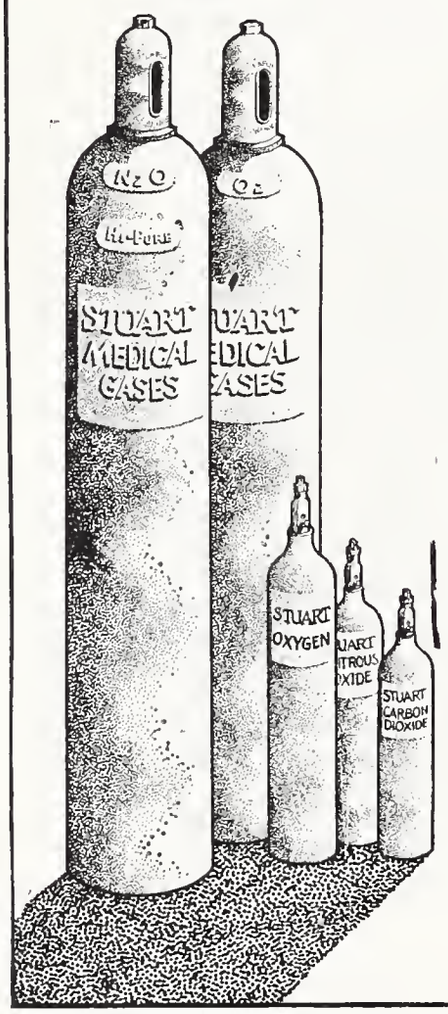
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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

rise, December 16, 1934). The records of the Board of Medical Examiners do not show any medical credentials held by Charles E. Baker.

"Holding that the evidence introduced before the State Board of Medical Examiners did not warrant the revocation of the license of Dr. George W. Fuller to practice medicine and surgery in California, Superior Judge Emmett H. Wilson on Friday, December 7, ordered the judgment of the Medical Board to be modified by striking therefrom the portion of the Board's judgment revoking Doctor Fuller's license and inserting therein a reprimand for the violation of the Medical Practice Act for making statements in a pamphlet issued by the doctor which were technically untrue. . . . Judge Wilson held that there was sufficient evidence to sustain the findings of the medical board that the advertising was contrary to the Medical Practice Act, but because the judgment announced by the Board was deemed too severe it was modified so as to carry a reprimand instead of a revocation of the license. . . ." (Los Angeles *Journal,* December 10, 1934.)

"When J. D. Dunlop, former San Bernardino stock salesman, failed to appear in Highland justice court yesterday for his trial on a charge of violation of the State Medical Practice Act, Justice J. W. Moore ordered the defendant's $100 bail forfeited and issued a bench warrant for Dunlop's arrest. . . . Dunlop was indicted by the grand jury two years ago on charges of violating the Corporate Securities Act, but the case was dismissed in Superior Court when San Bernardino County authorities were unable to extradite Dunlop's co-defendant from Arizona." (San Bernardino *Sun,* December 14, 1934.)

"All is not well in the British medical profession. Last week the British Medical Association and Scotland Yard held a sensational conference because bogus doctors are operating in increasing numbers throughout Britain. . . . Most of the bogus doctors are using names and appropriating the degrees of actual doctors practicing in all parts of the country, so that looking up the medical directory to see if a doctor is genuine is no check. Many of the bogus doctors have been taken on as partners by genuine doctors in all good faith. What Scotland Yard fears is that a wide traffic in illicit drugs is behind the sudden springing up of bogus doctors." (Press dispatch dated London, December 8, and published in the San Francisco *Chronicle,* December 9, 1934.)

"District Attorney Neil R. McAllister today revealed a prior conviction charge will be placed against L. P. Lorraine, male nurse, who is awaiting arraignment in the Superior Court on a charge of performing an abortion. The prosecutor stated he has proof Lor-

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raine served a term in the Indiana State Reformatory following his conviction in March, 1919, on a charge of burglary and grand larceny. . . ." (Sacramento *Bee*, December 19, 1934.)

"Convicted by a jury for failing to file reports of narcotic prescriptions, in accordance with the law, Dr. F. W. Starr, 5004 York Boulevard, today awaited sentence in Municipal Judge Alfred Paonessa's court. The elderly white-haired physician neglected to report prescriptions issued to Larry McLain last April 28 to the Division of Narcotics Law Enforcement, as required by State law, it was charged. McLain, a county jail prisoner, testified he had obtained narcotic prescriptions from the accused doctor at various times over a period of three months. Doctor Starr denied the charge." (Los Angeles *Herald-Express*, December 10, 1934.)

"Dr. H. B. Moore, 68-year-old San Diego chiropractor, was arrested today by Federal Narcotic Agent John Denison and charged with violating the Harrison Narcotic Act. . . . 'This arrest ends three years of work on the case by Police Chief George Sears, Osborn, and myself,' said Denison. Moore is accused of mailing 95 grains of morphin to his son, Arthur Moore, in Los Angeles. 'The morphin was concealed in a pair of stockings and underwear and mailed by special delivery to Los Angeles,' Denison said. 'The son is now in custody in Los Angeles and is awaiting trial on burglary charges and charges of violating the Harrison Narcotic Act.'" (San Diego *Sun*, January 2, 1935.)

"Dr. Frances McNealy was under arrest yesterday on a charge of forging narcotic prescriptions. She was arrested by federal officers, who said she had signed the names of other physicians to the prescriptions." (Los Angeles *Illustrated Daily News*, January 8, 1935.)

"Dr. C. E. Camp, sixty-nine, former San Pablo physician, serving a twenty-five-year sentence in San Quentin prison on a statutory charge involving a 16-year-old Richmond girl, today made application for parole, according to dispatches received from the State Board of Prison Terms and Paroles. Doctor Camp pleaded guilty to a statutory charge on January 28, 1928. He was arrested on January 23. On May 11, 1929, the State Board set his term at twenty-five years. . . ." (Richmond *Independent*, December 31, 1934.) (Previous entries, March and September, 1928; July, 1929.)

The Cancer Record of 1932*—Cancer at the present time has reached the position of being the second of the leading causes of death in the United States. The actual mortality from cancer has now reached the approximate total of 125,000 per annum. During the last five years the total number of deaths from cancer in the United States registration area, which comprehends about 95 per cent of the entire population, has amounted to more than a half million.

Year by year the crude death rate from cancer increases in this and most of the other leading nations. In 1900, or thirty-three years ago, the cancer death rate of the registration area was sixty-three per 100,000, while by 1930 the rate had risen to ninety-nine per 100,000, or in round figures, 50 per cent in thirty years. In 1911, the cancer death rate of England and Wales was ninety-nine for 100,000, which by 1931, or twenty years later, had reached 148.4, or again in round numbers an increase of 50 per cent.

In New York City the cancer death rate in 1812

* By Frederick L. Hoffman, LL.D.
Reprinted in part from *The Spectator*, April 27, 1933.

(Continued on Page 21)

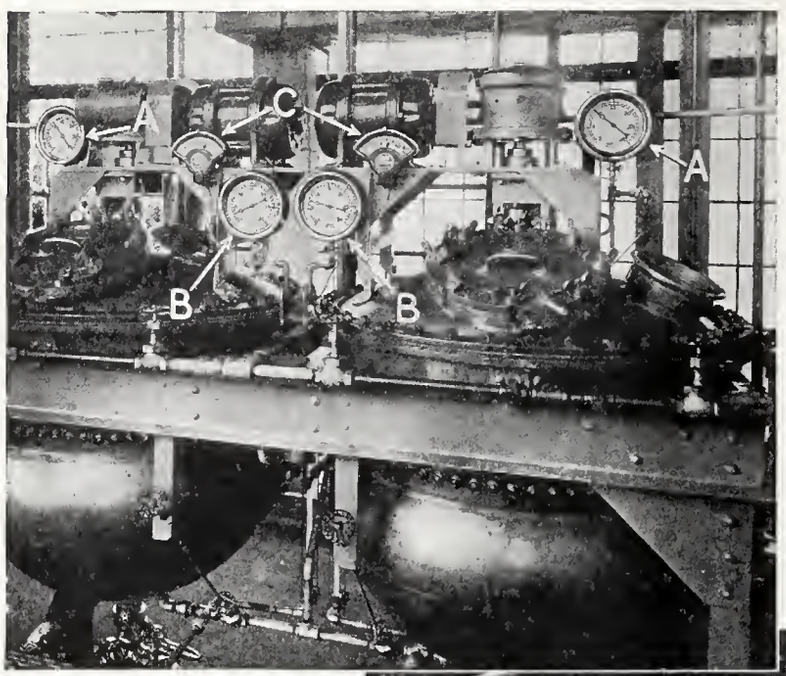
CONTROLLED Cereal Cookery

If you instruct ten different mothers, "Cook baby's cereal thus and so," there will be ten different results.

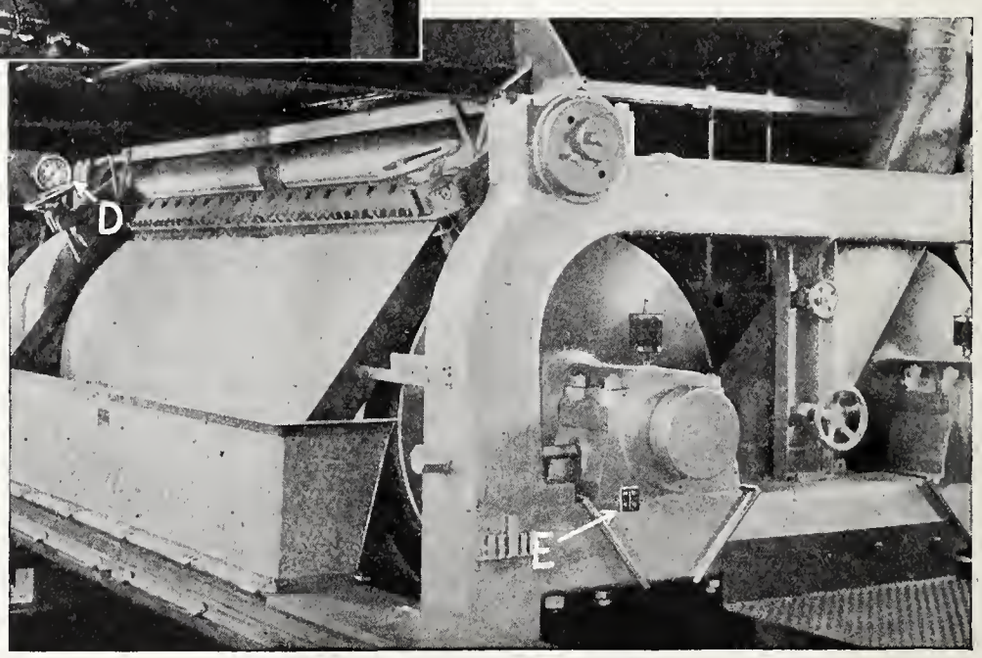
HOME-COOKED cereal is seldom a uniform product . . . because of many uncontrolled factors. The cook, for instance, rarely measures the cereal and the liquid accurately. Nor does she time the cooking carefully. Even if she does, the intensity of the heat varies. Further, the degree of evaporation differs.

Even the type of utensil is a factor. Cooking cereal in a double boiler is likely to cause a surface "skin" to form that is even less digestible than raw starch, Carman *et al* find from digestibility studies *in vitro* of breakfast cereals. They also report that single-boiler cooking for more than 15 minutes actually "decreases digestibility because of the formation of lumps produced by too rapid evaporation of water." This clumping is unavoidable without a condenser and with ordinary household utensils.

Pablum*, in contrast, is manufactured by a patented process and precision methods which insure a thoroughly cooked and uniform cereal. This is substantiated by *in vitro* studies of Ross and Burrill, which show that the starch of Pablum without additional cooking is more rapidly digested than that of oatmeal, farina, cornmeal, or whole wheat cooked 4 hours in a double boiler.



Left—Two double-jacket cookers in which Pablum is steam-cooked under rigid control. Live steam of uniform pressure and temperature flows into the cookers and displaces air above the cereal thus preventing oxidation and affording protection to vitamins and flavor. A unique paddle-knife constantly agitates the mixture so that a fresh surface is constantly presented to the steam. Note three gauges used in controlling cooking: (A) gauges maintaining uniform steam pressure in tops of cookers; (B) gauges regulating steam pressure in surrounding jackets; (C) thermometers for control of temperature (control of steam pressure and of temperature are both essential).



Right—One of many drum dryers used in the manufacture of Pablum. After the cereal mixture is steam-cooked it is dropped between revolving steam-heated rollers which roll and dry it in a uniform layer of material. Gauge (D) is used as a check on the steam pressure within the drums. Distance between them is maintained within thousandths of an inch by means of a micrometer plate (E).

*Pablum (Mead's Cereal pre-cooked) is a palatable cereal enriched with vitamin and mineral containing foods, consisting of wheatmeal, oatmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, iron, salt, and sodium chloride. Patent pending.

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(Continued from Page 19)

was only seven per 100,000. Fifty years later, or in 1862, the rate had reached twenty, while still a half century later, or in 1912, it had mounted to eighty-two; but twenty years later, or in 1932, the rate had reached 119.

Are these astonishing figures meaningless and merely a figment of statistical speculation, or are they obvious indication of a disconcerting increase in the cancer death rate essentially attributable to changes in the age and sex distribution of the population or due to improved diagnosis and better methods of death classification? I think not. Rather would I attribute the continuous and almost uninterrupted rise in the cancer death rate to profound changes in the habits and mode of life of modern population.

This conclusion I have arrived at in the light of thirty years of painstaking interest in the cancer problem entirely free from the professional bias of the general practitioner and the surgeon or the specialist in cancer control measures, aiming chiefly at earlier diagnosis and the qualified treatment of malignant disease.

I wish to draw attention to the great range in the cancer death rate of different countries representing a most puzzling aspect deserving of much more attention than is given to the variations, local and geographical, in the incidence of fatal cancers throughout the world.

Comparing five-year averages, the New Zealand year book for 1933 gives the following rates: Starting with an extraordinary low rate of only ten per 100,000 for Ceylon, or the same rate as recorded for New York in 1837, the rates for other select countries have been as follows: Salvador, 13; Jamaica, 23; British Guiana, 24; Greece, 24; Lithuania, 30; Trinidad, 40; Italy, 60; Spain, 68; Japan, 70; Canada, 87; France, 89;

(Continued on Next Page)

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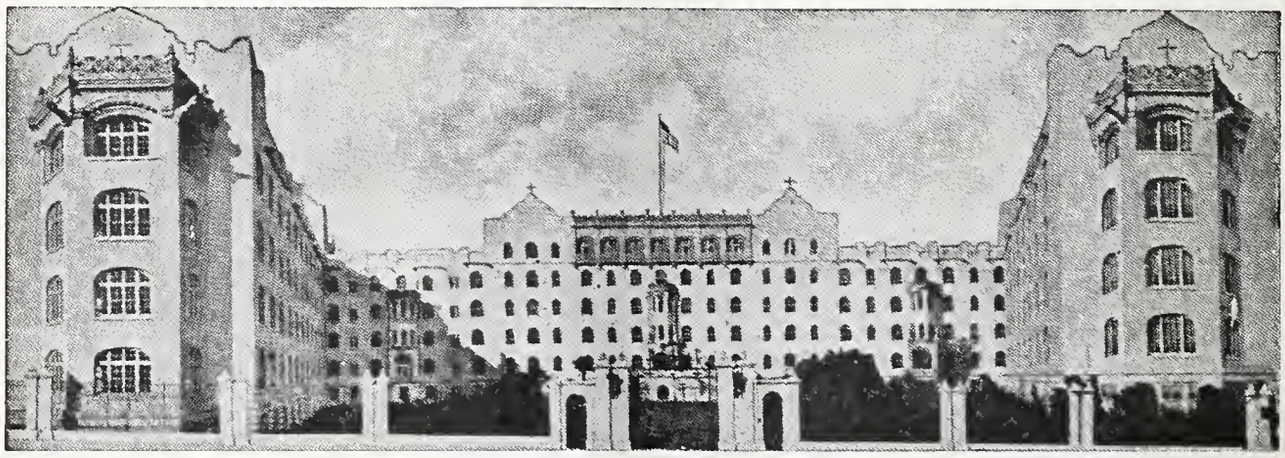
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(Continued from Preceding Page)

United States, 95; Australia, 95; New Zealand, 101; Germany, 116; Switzerland, 139; England and Wales, 141; Denmark, 141; Scotland, 143; Austria, 148. What explanation can be advanced for these disparities? What can be the local and underlying causative factors explaining a range in rate from ten for Ceylon to 148 for Austria?

It goes without saying that, in a country like Ceylon, with its teeming native population of which a large proportion are living in extreme poverty, medical attention is not what it might be and many cases of cancer must go unrecognized. But even if the rate were five times the recorded rate, the incidence of cancer would still be about a third of the Danish or Austrian rate.

The rise in the cancer death rate over a long period of years is admirably illustrated for the City of New York. I give the information below by ten-year periods. It would seem utterly incredible that these figures are meaningless and entirely invalidated by inaccuracies in death certificates.

CANCER MORTALITY IN NEW YORK CITY
1804-1932—RATE PER 100,000

1804-09	7.6	1870-79	41.0
1810-19	9.4	1880-89	51.2
1820-29	8.7	1890-00	57.6
1830-39	12.4	1900-09	71.0
1840-49	16.3	1910-19	86.2
1850-59	21.4	1920-29	106.3
1860-69	27.3	1930-32	117.7

The rising cancer death rates throughout the world lead to no other conclusion than that the increase in cancer is real and not apparent, although it goes without saying that allowance must be made during the last thirty years for an increasing average age and decided improvement in diagnosis and death certificates. But this cannot set aside the general conclusion that during the last fifty years cancer has been mounting step by step until it is now the second leading cause of death in the United States.

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Unquestionably changes in death classification have had some effect upon individual rates for particular organs and parts, such as cancer of the pharynx, but an extraordinary regularity is observed for most of the organs which have apparently undergone no material change. Thus cancer of the lip, one of the most easily diagnosed types, was 0.5 per 100,000 in 1915 and 0.5 in 1931. Cancer of the tongue was 0.8 in 1915 and again the same in 1931. Cancer of the stomach increased from 20.3 in 1915 to 21.3 in 1931. Cancer of the liver and gall-bladder decreased from 10.0 to 8.6, while cancer of the intestines increased from 6.9 to 9.6, which may possibly be attributable to better methods of classification.

There is a like increase for cancer of the rectum and anus from 3.1 to 4.6. There is also a decided increase in cancer of the ovaries and fallopian tubes from 0.3 to 1.7. Cancer of the uterus increased from 11.0 to 12.1 and cancer of the breast increased materially. Here is a form of cancer easily diagnosed. Cancer of the skin decreased from 2.9 to 2.5, while cancer of the lung and pleura increased from 0.7 to 2.4. Cancer of the prostate increased from 1.4 to 4.1. This is one of the most pronounced increases to which hardly any attention has been attracted. All the figures available for other countries are indicative of a like increase in cancer of the prostate which demands serious consideration.

Thus the actual increase in cancer has only been applicable to certain organs and parts.

The cancer death rate increased in eighty-four cities and diminished more or less or remained stationary in ninety-six others. The maximum figure was returned for Madison, Wisconsin, or the incredible rate of 295.8 per 100,000, due unquestionably to the admission of non-residents to local hospitals for special treatment.

I have summarized below the return for fifteen cities which in 1932 had a rate in excess of 150 for 100,000.

(Continued on Next Page)

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(Continued from Preceding Page)

CITIES WITH CANCER DEATH RATES IN EXCESS OF 150 PER 100,000—1932

Madison, Wis.	295.8
Concord, Mass.	220.1
Troy, N. Y.	211.2
Lancaster, Pa.	200.2
Portland, Maine	184.2
New Haven, Conn.	175.2
San Francisco, Calif.	165.7
Providence, R. I.	160.7
Pasadena, Calif.	159.5
Quincy, Ill.	157.7
San Diego, Calif.	157.3
Manchester, N. H.	156.8
Paterson, N. J.	156.7
Cambridge, Mass.	153.7
Minneapolis, Minn.	150.6

No explanation of the extraordinary figures for certain localities has been forthcoming, although it may be said that in certain New England states especially, the rate is increased by the larger proportion of aged persons.

I next give a tabulation of the actual deaths and rates in 1931 and 1932 for five of the largest cities of the country showing further disparities. In these cities during the two years under discussion the actual number of deaths from cancer increased from 17,700 in 1931 to 18,127 in 1932.

CANCER MORTALITY IN FIVE LARGE CITIES
1931-1932

	1931		1932	
	Deaths	Rate	Deaths	Rate
Chicago	3,867	111.8	3,904	110.8
Detroit	1,133	69.2	1,203	71.0
Los Angeles	1,743	132.2	1,737	125.7
New York	8,336	117.6	8,573	118.8
Philadelphia	6,621	133.3	2,710	137.0

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There were five cities during the year with rates of less than 50.0 per 100,000 as follows: McKeesport, Pa., 17.8; Hamtrack, Mich., 20.7; Winston-Salem, N. C., 40.0; East St. Louis, Ill., 43.4, and Union City, N. J., 47.8. It would be interesting to ascertain the local factors responsible for these unusually low rates which have been observed in former years.

Statistics are available for the State of New York up to 1932. While the rate for New York City in 1932 was 118.8 per 100,000, it was 115.6 in 1927-1931. For the remainder of the state, exclusive of New York City, the rate for 1932 was 131.8 against 132.9 in 1930 and 127.4 during 1927-1931. These results should arouse interest as suggestive of an even higher death rate outside of very large cities than the rates for metropolitan urban centers.

In view of the assertion that the apparent increase in the general cancer death rate is chiefly attributable to the age change of the population, it can be shown that the increase is actual and not apparent when the rates are based on the respective populations by age groups. It is maintained that the continuous increase in the cancer death rate is real and not apparent, affecting all ages over 55.

The foregoing data and observations are highly disconcerting to those who are at work in behalf of measures for cancer control. Diagnosis in cancer has not made satisfactory progress during recent years nor have exceptionally satisfactory results been forthcoming in cancer treatment. The problem of cancer still remains the most baffling aspect of medical and surgical science highly suggestive of increased efforts in the direction of research not only in cancer causation but also in treatment results.—The American Society for the Control of Cancer.

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The Importance of Cancer Education.*—One of the great social advances that may be credited to the practice of medicine in this generation is the willingness of the medical and allied professions to give instruction in the ways and means of preventing disease, not only to the student who will some day be entrusted with the prevention and cure of disease but also to the general public.

Despite the dread of advanced cancer, which is shared by everyone, including doctors as well as laymen, a large body of facts has been assembled which, if properly presented to a thinking public, will do much towards curing, or at least alleviating, and often preventing the factors that everyone fears most about this disease. If the layman has not learned of these facts in the course of his daily life, he should seek them from members of the medical profession to whom he can give his confidence.

There are a number of reasons for educating the public about the cancer situation which are not generally considered by those who are to benefit from such information. The question is often asked, Why teach persons about a disease which claims its victims by the tens of thousands and is so generally fatal in various painful ways? To begin with, there is something wrong with the question, for cancer is not always fatal or always painful; and in those cases in which the physician and surgeon are unable to cure or prolong life, symptoms are often alleviated by proper and timely treatment. Moreover, medical men of science know today, and so should the public, that in a goodly proportion of cases in which chronic irritation is the underlying cause of the malignant growth, cancer is preventable. In others, early diagnosis followed by early surgical intervention will cure. In still

* By E. M. Bluestone, M. D.

Reprinted in part from *Hygeia*, March, 1933. Dr. Bluestone is director of the Montefiore Hospital for Chronic Diseases, New York City.

(Continued on Page 28)

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Our bookkeeper fails to find your account settled on our books. Please help him out.



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Our records show that several statements and reminders have been sent you regarding the enclosed statement.

If your circumstances have made it impossible for you to pay the amount due, kindly write us promptly to that effect. Our office will then endeavor to extend all possible courtesies.

You appreciate, we are sure, that physicians, like other citizens, must pay their bills promptly. They can only do so, however, when their own clients in turn pay them promptly for such professional services as may have been rendered.

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Final Notice

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This collection bureau method is disagreeable to us; and we believe, also to you. By promptly sending your check all this can be avoided.

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IN THE SEPTEMBER, 1927, issue of CALIFORNIA AND WESTERN MEDICINE, page 398, appeared an article relating to the "collection of fees." Following this publication so many orders were received by us for printing the series of gum stickers and notices, we decided to print and stock the series in large quantities.

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*"Influence of Hygroscopic Agents * on Irritation from Cigarette Smoke."*

—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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* "Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation from Cigarette Smoke," as reprinted from Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245. ☐

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An easy-spreading lenitive ointment successfully used for many years in the treatment of burns; as a local application to denuded and painful lesions of the skin; as a lubricant. Packed in 2 oz. plain tubes, 1 lb., 5 lb., 10 lb., and 50 lb. containers.

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Represents Anti-Pyrexol and Gentian Violet, 1:200. Spreads easily on lint or gauze. Recommended for the treatment of burns; Tinea Circinata; Acute Dermatitis. Packed in 1 oz., and 1 lb. containers.

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Represents the lenitive oils of Anti-Pyrexol and Gentian Violet in solution. Recommended as a spray for extensive burns where open treatment is indicated. Forms light, tough, elastic, eschar that inhibits germ growth. Anodyne, non-toxic; bactericidal and bacteriostatic in vivo; mildly analgesic and aromatic. Possesses properties of great penetration. Suggested, too, in the treatment of cuts, scratches, tinea circinata, epidermophytosis; as an oral swab in the treatment of Vincent's angina, and affections in which staphylococci and B. diphtheriae are the causative agents. Packed in 1 oz. (with glass applicator), 4 oz. (with spray and glass applicator), pint, quart, and gallon bottles.

These Kip products are not advertised to the laity. Available through selected surgical supply houses and drug jobbers. For further technical information address Mona E. Bettin (M. D.), Pathological Laboratories, Roosevelt Building, Los Angeles, or

Kip Corporation, Ltd.

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** Reg. U. S. Pat. Off.*

(Continued from Page 26)

others, it will prolong life for many years, and in a definitely established group of cases, high voltage x-ray treatment and radium treatment in the hands of competent physicians are of considerable curative value.

Cancer is not only the concern of the individual patient who suffers from its effects, but also the concern of his neighbor. For the sake of both, the public should be told the facts. Whatever may finally be discovered to be the origin of cancer and the reason for its spread, one of the lessons that public health experience of the last few generations has shown is that the general health of the community depends in a great many ways on the health of its individual members, and this is true not alone of the infectious diseases.

The mere fact of being sick is not a disgrace, no matter what the sickness may be. To be sick, however, with a disease that could have been prevented with reasonable care is decidedly to the discredit of the patient, who is not the only one who takes the consequences, and also to the community, which may not have done its full duty in enlightening him. To continue to suffer from sickness under any circumstances, without seeking the relief which the medical profession individually and in its organized form can give, is a grave injustice to everyone concerned.

Cancer is a national menace, as proved by its increasingly large morbidity and mortality rates throughout the country, and one may reasonably expect increased government counteractivity with an awakened and insistent public opinion, on the part of both the layman and the physician. Much work in tracking down clues that present themselves in the laboratory and at the bedside is being done by the various public health agencies, through the application of public and private funds; but this work is not at all in proportion to the magnitude of the problem.

Although the cause and, in a large measure, the cure of cancer are not yet fully known, the medical



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profession is in possession of a large body of scientific facts about the natural history of this disease. These facts should be brought before the public to neutralize the activities of the nostrum vendors and the quacks who might otherwise have free scope for their practices among those who are not properly informed. As every intelligent person knows, unfortunately there are a number of cults which magnify out of all proportion some form of treatment that has a restricted scientific application; since the teachings of these cults naturally gravitate to the less educated members of the community, accurate publicity of the facts should be resorted to in an effort to combat their influence.

The public has imbibed a great deal of false information about cancer, as for example, in matters of heredity, infection and other theories about its origin and spread. The public is entitled to know the truth, as the truth is made known to physicians by the clinical and research laboratories of the medical and allied professions.

There is a definite and insistent demand for accurate information about cancer on the part of the layman. This demand is legitimate, and organizations for the control of cancer are prepared in numerous ways to meet it.

The obligation of the medical profession to teach the public how to get along without the doctor is fundamental and must apply in dealing with the cancer problem. In this day and age it is generally recognized that an ounce of prevention is worth a pound of cure.

Cancer education and cancer publicity should strike the proper medium and seek to transmit accurate information without unduly alarming the public. The fact that this is not being done in every instance cannot be put forward to support the contention that a campaign of public education is not worth while.

In the matter of cancer education, teachers are available; and it is for those who are interested to seek information and to encourage others to seek information from sources which are considered reliable. This educational process will do much to alleviate the suffering that is caused by ignorance of the circumstances under which this disease gains a foothold in the human body.—The American Society for the Control of Cancer.

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There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

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MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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The "New Deal" in Food Advertising.—Raymond Hertwig, secretary of the Committee on Foods of the American Medical Association, has the following to say on this subject:

The chaos in the economic and business world has given rise to the demand for a "new deal" in business and government. What is meant by this "new deal"? This "new deal" is the cry for the renewed recognition of the fundamental rights and privileges of the

(Continued on Next Page)

NITROUS OXIDE MEDICAL OXYGEN ETHYLENE

OXYGEN–CO_2 MIXTURES RESUSCITATING EQUIPMENT

ANESTHETIC MACHINES OXYGEN THERAPY EQUIPMENT

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(Continued from Preceding Page)

people for protection from fraudulent and deceptive public and business practices and operations; for the reordering of government and business that they both will function for the greater good of the people.

A similar chaos in the field of food advertising calls for a "new deal." Food advertising shall turn from deceptive, misleading, antisocial practices to advertising that respects the rights of the people for honest information and fair play. The "new deal" demands that the public be protected from advertising plunderers who pillage consumers by false claims and deceptive statements; from advertising trickery and chicanery for giving fraud the semblance of truth, and that the public be protected from advertising which manipulates facts solely to beguile and confuse.

The "new deal" calls for elimination of advertising competition that defeats straightforward honest advertising, but fosters subtle advertising, cunning and trickery. It is the responsibility of the food industry and advertising agencies to organize to protect themselves and the public from improper practices and outlaw advertising that violates the simple principles of honesty and trustworthiness. On the other hand, if manufacturers and advertisers are not willing or capable of controlling advertising in the interests of the public, then such control becomes a duty of the government. Whether ultimately government action will be necessary or not is up to the members themselves of these industrial groups.

It is time to critically question food advertising and determine whether it is serving the interests of consumers or serving against the interests of consumers. It is time to ascertain whether the business tax of hundreds of millions of dollars yearly levied on the people for food advertising by the food industry is being used for better public nutrition and health, or only for fattening and nourishing the purses of antisocial money seekers, quacks, charlatans, advertising jugglers and bootlegger food merchandisers. It is time for the food industry to realize sound and successful business is not based on advertising forgery. The industry is being led to failure only when food advertisers attempt to win business under false pretenses, cheap claptrap claims, counterfeit statements and forged truth, in any of their manifold forms. The day is past for merchandising success based on advertising banditry with contraband claims.

This "new deal" in food advertising calls for straightforward advertising truthfulness and honesty, for correct and proper simple advertising instruction on matters of foods, nutrition, and health; calls for trained and organized advertisers who recognize their duty to the public on matters of food advertising as a patriotic obligation. The "new deal" calls for the indictment as imposters those advertising and business adventures who break trust with their duty to good business and to public welfare. Are those who perpetrate false, deceptive advertising to cheat the public and break down sound, honest business anything other than traitors to society?

The Committee on Foods of the American Medical Association is doing its part for establishing the "new deal" in food advertising. The committee is laying down the principles of good advertising that will correctly and properly instruct the public. Those manufacturers and advertisers following the committee's rules are aiding society to rebuild prosperity and to prepare society for better nutrition and health in the future.—*Food Facts.*

Rabies Spreading in California.—Rabies is increasing in prevalence in many parts of California, and unless local communities take decisive action in the control of dogs—particularly stray dogs—the disease may cause tremendous losses in livestock, as well as in human beings. Since the disease is spread largely by stray dogs, the most important action at the present time lies in the destruction of all such strays.

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For the Hospitalization of Psychiatric, Neurasthenic and Addiction Cases

A valuable horse was recently shipped from Southern California to Sacramento, where it was entered in the horse show at the State Fair. On the day before the Fair opened, it was necessary to kill this blooded animal because it had developed rabies. Diagnosis was established through the examination of the horse's brain at the state bacteriological laboratory. It is presumed that the horse was bitten by a dog in the Southern California community whence it was shipped, as rabies has been widely prevalent in that community.

Since the first of the year, 415 cases of rabies in animals have been reported to the State Department of Public Health. Most of these were from Southern California, where the disease has been widely prevalent over a long period of years. During the past few weeks more cases have been reported in other parts of the state and at the present time the disease may be said to constitute a distinct menace to both man and animals.

A few weeks ago a police dog, three months old, was adopted as a camp pet in one of the Civilian Conservation Corps camps in Southern California. The dog became rabid and before it died more than eighty human beings had been bitten. In order to prevent the development of the disease, it was necessary for all of these individuals to undergo the Pasteur treatment for its prevention.

Recently an Irish terrier in Los Angeles bit twenty-five persons, including many women and children. The dog was shot by the police, and an examination of its brain proved that it was suffering from rabies. The cost of giving the preventive treatment to these large numbers of individuals is very great, and failure to control stray dogs constitutes false economy. It is far cheaper to control the disease at its source than it is to deal with the end-results. One of the most unfortunate features of this disease lies in the fact that it is children who are generally attacked by rabid dogs. Unless they are provided with the Pasteur treatment at once, their lives are placed in jeopardy.

Individuals who care most for their dogs—sportsmen and dog fanciers—and those who enjoy the companionship of dogs are most active in providing protection for their animal friends. By means of vaccination, dogs can be protected against contracting the disease. At the present time, however, the most logical procedure lies in the control of stray dogs. The great reservoir of infection is in the stray dog population.

Following are the numbers of cases of animal rabies reported in California counties since January 1, 1933:

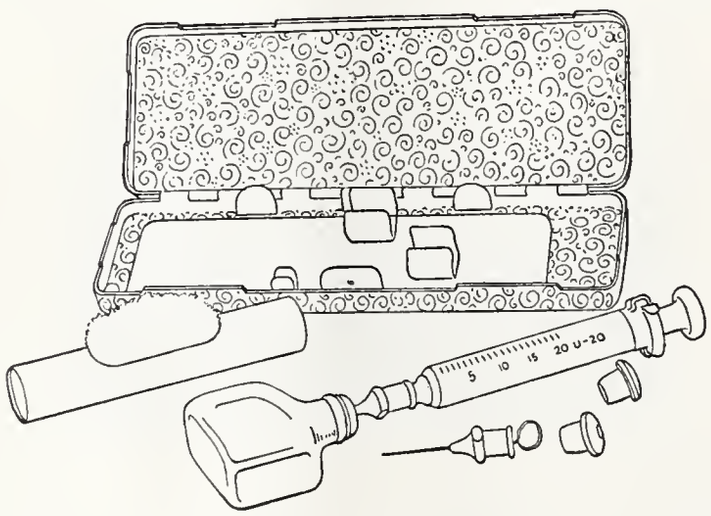
County	*Number of Cases*
Contra Costa	3
Fresno	2
Imperial	22
Kern	1
Los Angeles	304
Madera	1
Marin	1
Merced	11
Sacramento	3
San Diego	10
San Joaquin	34
Sonoma	1
Stanislaus	19
Tulare	3
Total	415

The most important quality of education is flexibility. Flexibility is allied to play. Play is the essence of adaptability, and there is no prescribed pattern for it. Opportunities must be used as they come along.—Boyd H. Bode (1932).

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Diabetics will find Lilly's Ever-Aseptic Syringe Case, No. 65, a great convenience. Small in bulk, it contains an Insulin syringe, two needles, a metal cylinder for cotton, a sterilizing flask, and rubber stoppers. Once assembled, the syringe and needle are always ready for use. Supplied together with a package of cotton, four ounces of iso-propyl alcohol, and a glass pipette.

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ACCREDITED REPRESENTATIVE OF THE CALIFORNIA AND NEVADA MEDICAL ASSOCIATIONS

Vol. 42 FEBRUARY, 1935 No. 2

STATISTICAL STUDY OF UTERINE RUPTURES† *

By Lyle G. McNeile, M. D.

AND

Raymond D. McBurney, M. D.

Los Angeles

Discussion *by Margaret Schulze, M. D., San Francisco; Donald A. Dallas, M. D., San Francisco; E. M. Lazard, M. D., Los Angeles.*

THIS is an age of preventive medicine. Much has been written in recent years about the toxemias of pregnancy, hemorrhage, sepsis, and the various other major factors which have contributed so largely to maternal and infant mortality in the United States, but there is an astonishing dearth of literature on the subject of rupture of the uterus as it occurs in the large obstetrical clinics of this country. With the idea of bringing out the most frequent causes of rupture of the uterus in the obstetrical department of the Los Angeles County General Hospital, the clinical aspects, pathology, treatment, and available means of preventing this obstetrical catastrophe, we are presenting this study for your consideration.

PERIOD OF TIME AND NUMBER OF CASES COVERED BY STUDY

All cases of rupture of the uterus occurring between January 1, 1923, and March 31, 1934, are included in this report. During this period there were 17,350 obstetrical cases admitted to the hospital. In these 17,350 cases, thirty ruptures of the uterus occurred, an incidence of one rupture in 578 deliveries, or 0.17 per cent. This study does not include traumatic ruptures occurring during criminal or therapeutic abortions, or from operative procedures in nonpregnant women; nor does the number of admittances, 17,350, include such cases.

† A statistical study of patients at the Los Angeles County Hospital (period 1923 to 1934).

* From the Department of Obstetrics and Gynecology, University of Southern California School of Medicine.

Read before the Section of Obstetrics and Gynecology of the California Medical Association at the sixty-third annual session, Riverside, California, April 30 to May 3, 1934.

CLASSIFICATION

Primary classification gives Group I, patients who had been delivered previously by cesarean section, and Group II, patients in whom a previous cesarean section was not a factor. With the ever-increasing use of cesarean section as a means of delivery, and the still unsettled question as to whether a previous cesarean section is always an indication for cesarean section in succeeding pregnancies, regardless of the indication for the first section, we have arbitrarily divided our cases into these two groups in order to properly present our statistics in regard to this phase.

REPORT OF CASES

A statistical study of Group I cases (patients who had had previous cesarean section).—Ten of the thirty cases of uterine rupture occurred in this group. The group is of sufficient importance to justify an abstract report of each case.

Case 1.—A Mexican woman, aged 24, gravida 2, para 1. Her first labor had been terminated by cesarean section, but the indication for operation was not known. The patient was admitted six hours after the spontaneous onset of labor at full term. On admission, there was a bulging and tenderness over the lower abdomen, which was not relieved by catheterization. *At operation,* two hours after admission, there was found a complete rupture of the uterus at the site of the previous scar, through which the child's shoulder protruded. There was no free blood in the abdomen. *Operation:* Classical cesarean section and sterilization. *Result:* The baby was alive. The mother made an uneventful recovery.

Case 2.—A white woman, age 19, gravida unknown, para 4. Her last labor had been terminated by cesarean section, the probable indication being eclampsia. The patient was admitted five and one-half hours after the spontaneous onset of labor at full term. *At operation,* three and one-half hours after admission, the placenta and dead fetus, with much free blood, were found in the abdomen. A complete rupture of the uterus had occurred at the site of the old scar. *Operation:* Supravaginal hysterectomy. *Result:* Convalescence stormy during first five days. Patient was discharged on tenth postoperative day in good condition.

Case 3.—A Mexican woman, age 17, gravida 2, para 1. Her first child had been delivered by cesarean section, the indication being unknown. She was in her sixth month of pregnancy when labor began spontaneously.

The patient was admitted to the hospital fourteen and one-half hours after the onset of labor, the history stating that a private physician had in her home attempted a manual dilatation of the cervix, and had given her two hypodermic injections, one being morphin and the other apparently pituitary solution. *On admission,* she was in great pain, but did not show evidence of shock until immediately before operation, three and one-half hours after entry. *At operation,* the placenta and dead fetus, with free blood and clots, were found in the abdomen. *Operation:* Supravaginal hysterectomy. *Result:* Uneventful recovery.

* * *

Case 4.—A white woman, age 38, gravida 5, para 3. Past obstetrical history incomplete, but from data obtained we believe that the patient had been delivered of her second child by cesarean section for an unknown indication, and the mode of delivery of her third child could not be obtained. She was at full term when labor was induced at home by her private physician, who administered castor oil and quinin. After twenty-six and one-half hours of labor she was admitted to the hospital, and gave a history of having had a sudden, sharp, tearing pain in the abdomen four hours before entry. *At operation,* immediately following admission, a complete rupture of the uterus was found at the lower end of the previous cesarean scar, but extensive adhesions on the anterior surface of the uterus concealed a large blood clot, effectively preventing any further bleeding from the rupture. *Operation:* Delivery of a living child by cesarean section, followed by supravaginal hysterectomy. *Result:* Uneventful recovery.

* * *

Case 5.—A Mexican woman, age 23, gravida 3, para 2. She had been delivered twice by cesarean section, but the indication was not known. The patient was admitted eighteen hours after the spontaneous onset of labor at full term. The patient's abdomen was tense and painful, but evidence of shock was first shown while she was being sent to the operating room, three hours after entry. *At operation,* a double uterus was found. There was a complete rupture at the site of the old scar, through which the trunk of a dead fetus protruded. The abdomen was filled with free blood. *Result:* The patient died during a supravaginal hysterectomy. *Pathological report:* Rupture of one side of a double uterus. The rupture was eight centimeters in length. Apparently both previous cesarean sections had been done on the same side of the uterus.

* * *

Case 6.—A white woman, age 18, gravida 5, para 2. She had been delivered twice by cesarean section, but the indication was not known. She was admitted shortly after the spontaneous onset of labor at the fifth month of pregnancy. Labor was uneventful for twelve hours after admission, when the patient had a sudden, sharp, abdominal pain, but showed no evidence of shock. Two hours later, she again complained of lower abdominal pain, and the uterus became irregular in contour. *At operation,* fourteen hours after entry, a complete rupture of the uterus was found at the site of the former cesarean scar. Adhesions between the uterus and abdominal wall prevented any bleeding. A dead fetus was delivered by cesarean section, followed by supravaginal hysterectomy. *Result:* The mother made an uneventful recovery.

* * *

Case 7.—A white woman, age 25, gravida 3, para 1. She has been delivered by cesarean section, but the indication was not known. The patient was at term, but was not in active labor. Two weeks previous to admission she had a few slight abdominal pains, and the day before entry she had had a sudden, sharp pain in the abdomen, which was followed by vaginal bleeding. *At operation,* three and one-half hours after admission, two incomplete ruptures of the uterus were found along the site of the old cesarean scar. The child was in good condition, and there was no free blood in the abdomen. *Operation:* Cesarean section, followed by supravaginal hysterectomy. *Result:* Uneventful recovery.

* * *

Case 8.—A white woman, age 18, gravida 2, para 1. Her previous child had been delivered by cesarean section, no indication being known. She was admitted twenty-seven hours after the spontaneous onset of labor at full term. It was stated that fifteen hours before entry a private physician had given her a hypodermic of morphin, the effects of which lasted for ten hours. During the five hours preceding admission, she had had continuous abdominal pain and moderate vaginal bleeding. *At operation,* one hour after entry, the placenta and dead fetus, with a large quantity of free blood, were found in the abdomen. *Operation:* Supravaginal hysterectomy. *Result:* Uneventful recovery.

* * *

Case 9.—A white woman, age 22, gravida 3, para 2. She had had two previous cesarean sections, the first section being done for a central placenta praevia. She was admitted three and one-half hours after the spontaneous onset of labor at full term. *At operation,* four hours after entry, there was found a complete rupture of the uterus at the site of the old scar, and through the rupture protruded a large portion of the placenta. There was considerable free blood in the abdomen. *Operation:* Cesarean section followed by supravaginal hysterectomy. *Result:* The child was alive. The mother's recovery was uneventful. *Pathological report:* Necrosis, hemorrhage and inflammatory reaction of the myometrium at the site of the rupture.

* * *

Case 10.—A Mexican woman, age 28, gravida 8, para 7. *Previous obstetrical history:* First labor, cesarean section for unknown indication. Second labor, spontaneous. Third labor, bag induction for eclampsia. Her fourth, fifth, sixth, and seventh labors were spontaneous. She was admitted seventy-two hours after the spontaneous onset of labor at the sixth month of pregnancy. During these seventy-two hours, the patient had had painful uterine contractions occurring about every fifteen minutes. Her contractions continued at ten-minute intervals for three hours, when they ceased and she showed evidence of shock. *At operation,* seventy-eight and one-half hours after the onset of labor, and six and one-half hours after admission, a complete rupture of the uterus was found at the site of the old scar. There were extensive adhesions between the omentum and the uterus, which prevented the escape of a large clot into the abdomen. A portion of the placenta protruded through the rupture. *Operation:* Cesarean section, followed by supravaginal hysterectomy. *Result:* A 1,150 gram fetus was stillborn. The patient had a stormy convalescence, her temperature ranged from 101 degrees to 103 degrees Fahrenheit. She was transferred from the ward because of wound infection, although showing gradual improvement, and died suddenly on the twenty-fourth postoperative day, of pulmonary embolism.

SUMMARY

Tables 1 and 2 present a summary for the Group I cases.

Table 1.—*Uterine Ruptures Following Previous Cesarean Section (Group I)*

Number of cases		10
Deaths, Maternal		2 (20%)
	Fetal	6 (60%)
Labor, Onset spontaneous		8
	Induced with castor oil—pituitary extract	1
	Not in active labor	1
	Duration of labor before entry	4 to 72 hours
Operation, Immediately after rupture		2
	(No deaths)	
	Delayed two to six and one-half hours	8
	(Two deaths)	

TABLE 2.—*Pathology Found at Operation in Uterine Ruptures Following Previous Cesarean Sections (Group I)*

Free blood in the abdomen	3
No free blood in the abdomen	4
Adhesions—preventing escape of clots	3
Types of rupture—complete	9
incomplete	1

COMMENT

All of the ruptures of the uterus in this group occurred at the site of the old cesarean section scar and, with one exception, were complete ruptures. A number of observers have protested vigorously against the dictum, "Once a cesarean, always a cesarean." De Lee[1] believes that a previous cesarean section may necessitate a subsequent section "(a) when the reason for the first one still exists, as in contracted pelvis; (b) when infection occurred after the first section; (c) when the previous section is known to have been done imperfectly; or (d) when a hernia in the scar, or other condition, makes it advisable to reopen the abdomen."

It is our belief that a nonfebrile postoperative course following a cesarean section does not in any way insure that the uterine scar is well healed. McNeile has found three complete ruptures of the uterus during the course of elective cesarean sections done before the onset of labor because the patient had previously had a cesarean section, and Case 9 of this series showed no evidence of rupture prior to operation.

Histological studies of the uteri of women who have had cesarean sections have apparently demonstrated that the strength or weakness of a cesarean section scar cannot be determined by any means which are available at the present time. It is certain that an afebrile convalescence is not a criterion of wound union.

Davis,[2] in a report of eighty-eight cases of ruptured uteri at the New York Lying-In Hospital, states that "while rupture through the cesarean scar in a subsequent pregnancy is a serious accident, the prognosis for the mother is far better than in the other cases of complete rupture." This statement is true in our series. The more favorable prognosis may be the result of, first, the lessened chance of infections having been carried into the uterus (and abdomen) through vaginal manipulation; second, the healed tissue in and about the previous cesarean scar does not bleed so freely as the tissue about a traumatic rupture; and third, adhesions about the scar often effectively aid hemastasis by favoring clot formation.

GROUP II CASES

Summaries for the Group II cases are presented in Tables 3 to 10, inclusive.

TABLE 3.—*Uterine Ruptures in Which a Previous Cesarean Section Was Not a Factor (Group II)*

Number of cases		20
Deaths, Maternal		18 (90%)
Fetal		13 (65%)
Nonviable	2	
Dead before delivery	4	
Died during delivery	5	
Died following delivery	2	

TABLE 4.—*Ages of Patients in Group II*

Youngest	20 years
Oldest	41 years

There was no predominating age group.

On the cases in which the diagnosis of uterine rupture was delayed, five were diagnosed at autopsy, while in eight cases operative procedures, having as their object delivery, had caused an undiagnosed uterine rupture before entering the hospital. Both Cragin and Davis have called attention to the fact that complicated cases gravitate to hospitals, and for this reason maternity hospitals cannot fairly estimate the relative frequency of this accident. Ten of the fourteen cases in which the diagnosis of the uterine rupture was delayed had been interfered with before entry to the hospital, and were sent in by private doctors.

TABLE 5.—*Previous Pregnancies—Patients in Group II*

No. of Cases	*Para*
1	0
2	1
2	2
4	3
1	4
2	5
1	6
1	7
1	8
1	9
1	10
1	11
2	Not recorded

A brief summary of the probable causes of uterine rupture in each case is sufficiently illuminating to justify presentation:

Case 1. Transverse presentation. Manual dilatation of the cervix, followed by an internal podalic version and extraction done in the presence of a threatened rupture of the uterus.

TABLE 6.—*Record of Race*

Caucasian	7 cases
Mexican	7 cases
Negro	4 cases
Japanese	2 cases

Case 2. Prolonged and forcible vaginal and intrauterine manipulation. Procedures included attempted version, craniotomy, followed by version and extraction.

Case 3. Attempted forceps delivery through an incompletely dilated cervix.

Case 4. Rupture occurred during an internal podalic version and extraction.

TABLE 7.—*Labor*

Onset—Spontaneous		13 cases
Induced		2 cases
Not recorded		5 cases
Induction—Castor oil and quinin		1 case
Colpourynter		1 case
Colpourynters used in		3 cases
Induction	1	
Prolonged first stage	1	
Low implantation, placenta	1	
Pituitary extract medication during		0 cases
Duration of labor, shortest		5 hours
longest		45 hours

TABLE 8.—*Presentations*

Cephalic	17 cases
Breech	1 case
Transverse	1 case
Unknown	1 case

Case 5. Rupture occurred during a manual dilatation of the cervix.

Case 6. Forceps delivery. The details could not be obtained.

Case 7. Rupture occurred during an internal podalic version and extraction.

Case 8. Manual dilatation of the cervix, followed by internal podalic version and extraction.

CASE 9. Rupture of the uterus resulted from an attempt to apply forceps to a breech presentation.

Case 10. Rupture of the uterus occurred during a delivery which included manual dilatation of the cervix, attempted forceps, and craniotomy.

Case 11. Rupture occurred during a forceps delivery with the Kielland forceps.

Case 12. Forcible attempt to perform an internal podalic version and extraction in the presence of a contraction ring.

Case 13. Rupture occurred during an internal podalic version and extraction.

TABLE 9.—*Operative Procedures During Labor*

Manual dilatation of the cervix	4 cases
Dührssen's incisions	1 case
Internal podalic version and extraction	7 cases
Breech extraction	1 case
Forceps delivery	3 cases
(One Kielland forceps)	
Craniotomy	2 cases
Kristellar expression	1 case
Manual extraction of placenta	6 cases

Case 14. Rupture occurred during an attempted forceps delivery which was followed by an internal podalic version and extraction.

Case 15. Apparently ruptured spontaneously. The uterine contractions were said to be very hard.

Case 16. Case handled by a midwife. There was a cephalopelvic disproportion. The uterus apparently ruptured spontaneously.

Cases 17, 18, 19, and 20. Cause unknown.

COMMENT

Thus, of the twenty cases of rupture of the uterus occurring in patients who had not been delivered previously by cesarean section, but two recovered. An immediate diagnosis of rupture was made in these cases. *In the first,* the history shows that the cervix had been manually dilated from five centimeters, forceps delivery attempted, and the labor finally terminated by craniotomy. During a manual removal of the placenta, many small incomplete tears in the uterine muscle were noted. The uterus was packed, and the patient was transfused, and given supportive treatment. Convalescence was uneventful. *In the second case,*

TABLE 10.—*Uterine Rupture*

Diagnosis—	Immediate	6 cases
	Delayed	14 cases
Signs of shock following		
	Immediate	12 cases
	Delayed	6 cases
	Not recorded	2 cases
Pain following		
	Extremely variable both in degree and constancy.	

TABLE 11.—*Probable Cause of Uterine Ruptures in Group II Cases*

Spontaneous	2 cases
Manual or instrumental manipulation during labor	16 cases
Not recorded	2 cases

where the patient recovered, an internal podalic version and extraction had been performed one and one-half hours after complete dilatation. A diagnosis of incomplete rupture of the uterus was made during manual removal of the placenta. At operation, immediately after diagnosis, an eight centimeter, incomplete rupture in the lower uterine segment on the left side, was found. There was hemorrhage into the left broad ligament. The operation was supravaginal hysterectomy. Convalescence was very stormy, and the patient was not discharged until the fiftieth postoperative day.

ETIOLOGICAL FACTORS IN RUPTURE OF THE UTERUS

Predisposing Causes.—Disproportion between the presenting part and the pelvis, and a uterine

TABLE 12.—*Statistical Data Relating to the Uterine Ruptures in Group II*

Type—	Complete	18
	Incomplete	2
Site —	Limited to fundus	1
	Lower uterine segment	17
	Anterior surface of uterus	7
	Posterior surface of uterus	2
	Left side of uterus	7
	Right side of uterus	3
Direction of Rupture—	Transverse	6
	Longitudinal	13
Extension—	Upward from cervix	3
	Into broad ligament	7
	Into fundus	3
	Into bladder	1
Free blood in abdomen		10
No free blood in abdomen		10

scar of a previous cesarean section are definitely shown to be the most important predisposing causes.

Exciting Causes.—Ill-advised, and unskillfully executed operative procedures for the termination of labor, particularly when undertaken in the presence of a thinned-out lower uterine segment, are the most common exciting causes. Although the improper use of ergot and pituitary preparations during labor is definitely known to be an extremely important exciting cause, no ruptures in this series were brought about through use of these drugs. Doctor McNeile has personally seen a considerable number of ruptures resulting from the use of pituitary solution during the first and second stages of labor, and again stresses the danger of improper pituitary medication during labor. External violence as a cause of uterine rupture is so rare that it is only of academic interest.

TABLE 13.—*Treatment Following Uterine Rupture*

Supravaginal hysterectomy	9
Suture of rupture	1
Repair of bladder, uterus unrepaired	1
Died during attempted laparotomy	1
Diagnosis not made prior to autopsy	5
Delayed diagnosis, no operation	1
Condition too poor for operation	2

DIAGNOSIS

Threatened rupture of the uterus may occur without symptoms, particularly when there is a scar from a previous cesarean section. The classical picture is usually present, however, and is easily recognizable if the patient is carefully observed. There is no progress in spite of hard uterine contractions. The uterine contractions are unusually painful, and the abdomen is very tender, particularly over the lower uterine segment. There are signs of exhaustion, with a rising pulse rate. There is little or no interval between uterine contractions. The fetal heart tones always show variations from normal rate and quality. The so-called "contraction ring of Bandl" may or may not be present.

Rupture of the uterus may, and frequently does, occur without characteristic signs and symptoms. Usually, a sudden, tearing pain, followed by the cessation of uterine contractions, disappearance of the contraction ring, recession of the presenting part, and softening and tenderness of the abdomen are pathognomonic. The uterus (if the fetus has passed through the rupture into the abdominal cavity) is now apt to be small, well contracted, and pushed to one side of the lower abdomen. The blood pressure drops, and the patient presents the picture of a patient in shock. The symptom, external bleeding, is not constant, and is not of diagnostic importance. *From a practical standpoint,* any evidence of shock during or immediately following labor should call for the serious consideration of rupture of the uterus as a possible cause. This is particularly true if any operative procedure has been attempted, if pituitary solution or ergot has been used prior to delivery, or if the history of the case discloses any previously existing condition or operation which might tend to weaken the uterine muscle. Thus, a curettage, a salpingectomy with excision of the uterine cornu, or the removal of an adherent placenta in previous labors, might be of etiological interest. De Lee makes it a rule after every operative delivery, whether or not symptoms are present, to examine the uterus, at least the lower uterine segment, with the whole hand, and determine, beyond suspicion of a doubt, the extent and location of any injury. We believe that this is good practice, and should always be done when the conditions are proper, and a rigid aseptic technique can be carried out.

TREATMENT

Davis says: "The time to treat rupture of the uterus is before it occurs. In the last analysis, this means better, more conscientious, and systematic care during pregnancy and labor." The most important prophylactic measures include the avoidance of unintelligent use of ergot and pituitary preparations during labor, and a more conservative attitude in terminating pregnancy or labor by operative measures.

It is the belief of the authors that no fixed procedure is applicable in the treatment of actual rupture of the uterus. Each case must be individualized. In general, supravaginal hysterectomy, immediately after the rupture has occurred, will give best results. In a not inconsiderable number of cases, particularly in young women desiring additional living children, the suturing of the rupture will give satisfactory results, and, in two such cases, Doctor McNeile has subsequently delivered living children by cesarean section.

CONCLUSIONS

1. In 17,350 consecutive obstetrical cases admitted to the Los Angeles County General Hospital, there occurred thirty uterine ruptures, an incidence of one in five hundred and seventy-eight cases.

2. Rupture of the uterus is nearly always preventable.

3. While rupture through the cesarean scar in a subsequent pregnancy or labor is a serious accident, we find that the prognosis for the mother is far better than in the other cases of complete rupture.

4. The radical attitude adopted by many physicians in attempting operative procedures to shorten labor, without regard for proper obstetrical indications or conditions, is shown to be the predominant factor in causing rupture of the uterus in cases not caused by the rupture through a cesarean section scar.

5. A patient who has had a cesarean section should be delivered by cesarean section at or near term, in subsequent pregnancies.

6. The prognosis in cases of rupture of the uterus depends to a great extent upon the immediate recognition and treatment of the condition.

The authors are convinced that after every operative delivery the lower uterine segment should be examined manually to determine the presence of possible injury, if aseptic conditions are satisfactory.

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REFERENCES

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DISCUSSION

Margaret Schulze, M. D. (University of California Hospital, San Francisco).—Doctor McNeile has given us an excellent discussion of a subject of constantly increasing importance. The high incidence of cesarean section at the present time brings up for our consideration each year the problem of delivery in a number of pregnant women having a cesarean scar in the uterus. When the initial operation has been done for a pelvic indication, the indication, of course, remains, and all are agreed that a repeated section is the only method of delivery to be considered. Much discussion has centered about the type of delivery when the indication for the first cesarean no longer exists; that is, whether a uterine scar *per se* is an indication, as is maintained by those who uphold the dictum "once a cesarean, always a cesarean." I agree very definitely with the essayist that it is, for we have no method of determining which uterus is likely to rupture, and which is not. It is generally stated that infection and faulty suturing predispose to later rupture of the scar, and this is true; yet competent surgery and an afebrile convalescence are no guarantee against it, as increasing experience shows. Nor have we any practicable way of determining placental implantation over the scar—an important predisposing factor. It was at first felt that the scar in the low cervical cesarean would be far less likely to rupture;

yet cases of this type are gradually accumulating, one being reported by Doctor Maxwell from the University of California Clinic, and many others elsewhere. The generally stated incidence of rupture (from 2 to 4 per cent) might make us wonder whether the risk of repeated section were not greater than the danger of rupture. Yet these statistics are fallacious, for they do not consider the method of delivery. Thus Wilson reports, from the Johns Hopkins Clinic, an incidence of 2.2 per cent of uterine rupture in 133 pregnancies following cesarean section in one hundred women. But eighty-eight of these pregnancies were terminated by repeated section, and hence were not subjected to the strain of labor. The ratio of rupture to successful delivery by the natural passages was 3:39, or 7.6 per cent. Eardley Holland's collective investigation of British hospitals showed an incidence of eighteen ruptures in 448 repeated pregnancies, or 4 per cent, and the proportion of ruptured scars to successful delivery by the natural passages was 18:78, or 23 per cent. This was truly a formidable figure, and one which does not well support a policy of watchful waiting even under the most careful observation, nor does Wilson's objection that cesarean section cannot prevent the considerable proportion of ruptures which occur before the onset of labor seem to me a very valid argument. If so many cannot stand even the strain of pregnancy, should we subject any to the far greater strain of labor? Doctor McNeile's case No. 10 is of great interest. One might consider a single successful labor after a cesarean section a fair test of a scar, and feel less concern about allowing a succeeding pregnancy to terminate by the natural passages. However, this woman had six such deliveries, even including one bag induction, but ruptured her uterus in her eighth labor in attempting to deliver an 1,150-gram fetus.

The relatively good prognosis of rupture following cesarean section is well illustrated by Doctor McNeile's series. More careful observation and earlier recognition may be a factor here in addition to the very important ones mentioned.

The prophylaxis of spontaneous rupture is merely good obstetrics, and in a properly handled case it should not occur. We cannot overemphasize the danger of pituitary solution during active labor, and feel that our rule, that it is never to be given by an intern without consultation with a staff member, is a good one. The danger of operative manipulations in the presence of a thinned-out lower uterine segment is well illustrated in this series. Complete relaxation under deep anesthesia before any attempt at version and extraction is most important and may serve to prevent some of the ruptures due to this cause. The development of the cervical cesarean section is an important factor in prevention, since we may give the patient a test of labor and not be impelled to deliver her from below if her progress makes it seem improbable that she will deliver herself. The examination of the lower uterine segment after every operative delivery in which rupture might have occurred seems a wise precaution, since it permits recognition of the condition before the onset of symptoms; and as was indicated in the paper, early recognition and treatment are the most important factors in prognosis.

Donald A. Dallas, M. D. (490 Post Street, San Francisco).—This paper has brought to our attention a very interesting group of patients. The extreme seriousness and relative frequency of rupture of the uterus are not ordinarily appreciated by anyone except the experienced obstetrician. However, any condition which occurs once in every five hundred deliveries, and carries a maternal mortality of from 20 to 90 per cent, and a fetal mortality of more than 60 per cent should be called to the attention of the medical profession.

I have always felt that "once a cesarean always a cesarean" is a doctrine fundamentally sound and will, in the long run, save a great many lives. Last year I had the unique experience of actually seeing the uterus rupture while doing a cesarean section on a patient who had previously had two cesarean sections. The site of the rupture was the scar of a classical cesarean which had gone through a second pregnancy, and had been inspected at the time of the second cesarean. The third pregnancy was uneventful. The patient entered the hospital several days before term, and had had a few mild pains before being taken to the operating room for the third cesarean. On opening the abdomen the lower angle of the scar had also opened and the amniotic fluid could be seen through the peritoneum and membranes. While inspecting this area the uterus contracted and the scar opened to its full length. There was only a small amount of bleeding from the ruptured scar. The peritoneum was incised, and the opening in the uterus was extended about one inch, and the baby delivered through the rupture. The edges were freshened and the wound closed in the usual manner. This case demonstrates very nicely the point emphasized in this paper—that there is generally little hemorrhage from the rupture of an old cesarean scar—and accounts for the low maternal mortality in this class of cases as compared with ruptures of the uterus from any other cause.

I could not help being impressed with the summary of probable causes of uterine rupture in the second group of cases. The first thing that struck me was the fact that at least eight out of the twenty uteri had been ruptured during the performance of internal podalic version. This operation is, in my estimation, the most dangerous one, for both the mother and child, used in obstetrics. I must prefer low cesarean section in those cases where there is a choice between the two operations. The second striking thing in this list is the fact that there was apparently only one spontaneous rupture of the uterus. In other words, in nineteen out of the twenty cases probably the uterus was actually ruptured by the operator. It is my impression from the few cases of rupture of the uterus that I have seen, and from this paper, that it occurs almost exclusively in patients who should have been delivered by cesarean section.



E. M. Lazard, M. D. (1930 Wilshire Boulevard, Los Angeles).—The authors' most interesting study of the uterine ruptures occurring in our services at the Los Angeles General Hospital furnishes material for several very interesting conclusions.

In Group 1—those following previous cesarean sections and comprising one-third of the entire series—the authors do not so state, but all of those ruptures followed previous sections of the classical type. The reason of the comparative frequency of rupture following the classical type of operation and rarity of rupture after the low cervical operation, is not only due to the better healing of the uterine wound after the low cervical operation, but also, I believe, to the comparatively frequent implantation of the placenta over the uterine cicatrix of the classical operation and rupture by erosion of the placental villi. In at least one of the cases reported, Case 9, and possibly three others, the placenta had covered the cicatrix of the former operation. While there have been a few cases of rupture following the low cervical operation reported, so far as I know there has not been reported a rupture before the onset of labor, after the low cervical operation. In one of the patients, No. 7, following classical section, rupture took place before the onset of labor, and I recall at least two other cases of rupture, in my service at the Los Angeles General Hospital, before the onset of labor. Both these cases antedated the period covered by this report. These cases confirm the claim made by its proponents of the superiority, from the standpoint of safety in future pregnancies, of the low cervical over the classical procedure.

I fully agree with the authors that any pregnancy, following a previous section, should be terminated by section at or near term. While I have delivered patients *per vias naturales* after previous sections, these were patients who were well advanced in labor,

with head well engaged and os completely dilated when first seen. In any patient in whom previous section has been done, whether of the classical or low cervical type, and where the patient is under my care before the onset of labor, I insist on repeating the section at term or at the onset of labor, as I refuse to watch such a patient in labor, and wonder if and when such scar is going to rupture.

In reviewing these case reports, one is amazed at the temerity of some attendants in carrying out such procedures, such as induction by the administration of castor oil, quinin and pituitary, manual dilatation of the cervix, etc., in these previously sectioned patients.

The results of operation in the first group, showing no mortality in the two cases operated on immediately after rupture, and two deaths in those operated on in from two to six and one-half hours, demonstrate the value of early recognition and operation in the cases.

The second group of cases, those in which previous section was not a factor, justify the author's conclusion, which I would emphasize, *viz.*, "The radical attitude adopted by many physicians in attempting operative procedures to shorten labor, *without regard for proper indications or necessary conditions,* is shown to be the predominant factor in causing rupture of the uterus in cases not caused by rupture through a cesarean scar."

Of the twenty cases, forcible operative attempts (including manual dilatation, forceps, version, and craniotomy) were made in all but two. One of the latter was the case of gangrene of the lower uterine segment, which I have hitherto reported.

Aside from this, the remarkable feature of this group is the mortality of 90 per cent, as contrasted with a mortality of but 20 per cent in the section group. This is readily understood when the shock of a prolonged labor and operative attempts, and the great degree of probability of infection having been introduced, are taken into consideration.

PERITONITIS AND DRAINAGE*

A PATHOLOGICAL AND CLINICAL STUDY

By GEORGE K. RHODES, M. D.
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DISCUSSION *by John D. Dameron, M. D., Stockton; Charles T. Sturgeon, M. D., Los Angeles; Emmet Rixford, San Francisco.*

TREATMENT of peritonitis must be divided between general supportive measures and surgical procedures. Since patients with peritonitis die of ileus, toxemia, dehydration, starvation, loss of chlorids, etc., we recognize the urgent need of adequate supportive treatment throughout the illness and convalescence. The rationale of general supportive treatment is generally well understood and practiced by surgeons today. The surgical treatment of peritonitis, however, is still a field for much stubborn controversy.

The diagnosis by the profession of "acute surgical abdomen," is now being made with increasing accuracy. In fact, probably too often, ill-advised operations are done hastily by overzealous surgeons. The dangers of delayed surgery are becoming less of a problem than those of ill-executed surgery.

Why do more people die from appendicitis in the United States than in any other country?[1] Is the incidence of the disease becoming more frequent, is it more virulent, or are those who undertake to treat the conditions negligent of their obligations? Should not each of us enroll in a campaign to study and further disseminate certain knowledge of peritonitis which seems fairly well established by laboratory tests and clinical trials?

PHYSICAL AND PATHOLOGIC CHANGES OF PERITONITIS

With the onset of peritoneal irritation there early develops an acute transudate which may vary in nature from clear straw-colored fluid (as in tuberculosis) to a thick turbid exudate filled with leukocytes and bacteria. With the development of the exudate, there is a precipitation of fibrin wherever irritant or foreign material is most concentrated.

It is by means of this exudate that the leukocytes and lysins called out are able so effectively to combat and overcome infections within the abdominal cavity. The presence of fibrin still further walls off infections, thereby preventing their spread and the absorption of toxins.[6]

Intestinal movements are remarkably inhibited throughout the course of peritonitis, and this also illustrates one of nature's many means of lessening the spread of infection. As peritonitis progresses, a paralytic ileus develops as the beginning of a series of reactions, a vicious circle that tends to bring about the patient's death. Often the plastic peritonitis which develops may so involve the bowel that a mechanical obstruction is superimposed upon a threatened paralytic ileus. If the damage to the peritoneum is severe, the thick fibrinous deposits later may organize into dense adhesions and become important factors in precipitating most of the later intestinal obstructions. In less severe reactions, only filmy adhesions develop, which may be entirely absorbed later.

BACTERIOLOGY

The bacterial flora found in peritonitis will vary with the nature and source of the infection. If the gastro-intestinal tract is the source of contamination, the numerical rate of the bacteria found, and their specificity, vary from zero in the stomach to maximum proportions in the large bowel.

Routine careful cultural studies on 106 cases of perforated appendix were made by Meleney in 1931.[2] In this series there was an incidence of *B. coli* in 87 per cent of the cases, green streptococci in 49 per cent, and *B. welchii* in 38 per cent. These three were the most prevalent types found in a total of twenty-three groups isolated. It is evident that there is a multiplicity of bacterial groups isolated in case of individual contamination from the appendix or large bowel. The clinical picture of peritonitis which may result from such a contamination will depend to a certain extent upon the virulence of the predominant bacterial growth and the environment present for this growth. Marchini[4] pointed out that the peritoneum has greater power of defense than any other tissue,

* From the Department of Surgery, University of California Medical School.
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and this defense is increased by inflammation, especially that caused by *B. coli*. Gueri,[5] of Rome (1932), writing on absorption of *B. coli*, concluded that absorption is in inverse ratio to the degree of peritonitis. The absorption of toxins and bacteria is probably directly through the peritoneum into the circulation, and also by way of the thoracic duct, as shown by David.[6] Experiments such as those by Steinberg[7] (1928) show that virulent cultures introduced into the peritoneal cavity kill the animals within twenty-four hours. These animals showed a hemorrhagic transudate and evidence of acute peritoneal injection, quite similar to the rare primary streptococcic peritonitis in human beings, but did not develop a typical plastic peritonitis unless a solution of 2.5 per cent gum tragacanth was used with the culture.

The rôle of the thoracic duct in carrying toxins and bacteria into the general circulation has received careful study. Aside from the technical difficulties of controlling all the anastomases of the thoracic duct, the experiments of David[6] (1927), indicate that drainage of the thoracic duct, as suggested by Costain,[8] would offer little help in therapy. David, after first controlling the anastomoses, inserted a cannula into the thoracic duct and another into the femoral artery. Lethal cultures then were injected into the peritoneal cavity and the animals experimented upon all died within twenty-four hours of toxemia, and bacteriemia and positive growths were obtained from both thoracic duct and femoral artery.

David[6] also showed that if a plastic type of peritonitis were produced experimentally, no growths were obtained from either the thoracic duct or blood stream. From this type of experiment we must assume that the major problem in plastic peritonitis does not concern itself primarily with septicemia or bacteriemia. It is rather a problem of ileus.

Furthermore, Halsted[9] and others[1,2] proved experimentally that it is almost impossible to produce a real plastic peritonitis without the introduction of some foreign material or chemical irritant in addition to the virulent culture used. Experimental studies indicate that the degree of toxemia or bacteriemia, which results from an introduction of a pure cultural growth or of toxins into a normal or irritated peritoneum, is distinctly inhibited as a plastic peritonitis develops. Morton[3] (1927) observed that peritoneal absorption of phenolsulphonephthalein likewise was decidedly retarded under similar conditions.

Thus it is evident that, with the onset of plastic peritonitis, the normal powers of absorption are markedly restricted, and nature attempts to confine the disease to the peritoneal cavity. Clinically we often are surprised at the apparent freedom from toxicity in the patient with peritonitis for several days, until the more tragic, foreboding signs develop with the onset of paralytic ileus.

The hope of the bacteriologists, that they may solve the therapy of peritonitis, seems distant at this time. Their aim might best be directed at some general or specific measure which would rapidly mobilize the lysin and phagocytes of the peritoneal exudate. On account of the multiplicity of organisms, any specific vaccine necessarily must be of a polyvalent nature. The therapeutic value of bacteriophages and variously prepared lysates needs much honest clinical study with proper controls before it can withstand unbiased scientific criticism.

Steinberg[7] and his workers apparently were able to produce a relative immunity by the injection of killed B. coli into the peritoneum of dogs. These immunized animals responded with a higher concentration of leukocytes in the peritoneal fluid, and this suggests that possibly the apparent beneficial results arise from this concentration rather than from specific antibodies. The results of such studies, however, probably are most applicable to prophylaxis rather than to therapy. Experimental work would suggest that peritonitis is a process of immunity which limits the infection and prevents the sepsis to which the unimmunized animal succumbs.

EXPERIMENTAL STUDIES OF PERITONITIS

Reference already has been made to the difficulty of producing a plastic peritonitis in animals which is comparable to that seen in man. Most laboratory workers[6,7,9] are agreed that it is almost impossible to produce a plastic peritonitis experimentally with simple bacterial cultures. It is necessary to add some foreign material such as gum tragacanth, rubber drain, or chemical irritant in order for the growth to initiate a typical plastic peritonitis. Benians[10] in 1924, showed that the peritoneum of normal rabbits rapidly lyses large numbers of living B. coli with no ill effects. This normal protection is upset by the presence of 0.5 per cent gum tragacanth, so that the animal is overcome by the same dose of the virulent culture.

The nearest approach to an experimental duplication of the pathologic picture of peritonitis probably is the work done by Droegmüller and Heilman[11] in 1931. They produced peritonitis in dogs by opening a loop of ileum approximately 40 centimeters long, leaving the mesentery intact, and restoring the continuity of the gut around the loop. This method, they stated, gave essentially the same pathologic picture as is seen in human diffuse peritonitis. (There is the exception, however, that in the dog, ileus is a rare occurrence, probably because the intestinal musculature is stronger, and the exudate somewhat more profuse.) In the control animals, this experimental peritonitis, by means of the open loop, was fatal in 90 per cent of the cases, with an average duration of four days. Thirty-three animals were operated on in one series, and when examined at the end of twenty-four hours all showed a spreading plastic peritonitis covering approximately one-half of the peritoneum but not extending down into the pelvis or up onto the diaphragm. This stage, according to the authors, corresponds to what would be seen in the human being after six hours, because leakage from the dog's bowel is slower. The intensity of the peritoneal reaction was found to be greatest at the focus of contamination and to decrease radially. Free loops of bowel might be covered with fibrin, without show-

ing obvious pathological change beneath it. In the thirty-three animals, the contaminating loop of bowel was removed at the end of twenty-four hours, to clear up the focus of infection, and the abdomen was closed without drainage. Nineteen (58 per cent) of these animals died, five with local and fourteen with general peritonitis. Of this same group, however, fourteen (42 per cent) survived and were sacrificed in from fifteen to sixty-five days. In no case was any gross purulent exudate found in the abdomen.

In a second series of twenty dogs, the abdomen was likewise reopened after twenty-four hours, the contaminating loop was removed, and two rubber drains were inserted, one toward the pelvis and one into the upper abdomen, crossing the soiled area. Of the eighteen dogs which survived the second operation, seventeen died of suppurative general peritonitis, and one of streptococcic pneumonia, a mortality of 100 per cent. At autopsy the drains were found to be encapsulated so as to prevent their function as drains, the lower abdominal drains being more completely walled off because of the position of the omentum. The use of intra-abdominal drainage had increased the rate of mortality of peritonitis in these animals from 58 to 100 per cent.

The authors concluded that drains in a spreading peritonitis are worse than useless, and do not extraperitonealize a zone which is the site of such a process. They suggested that, in clinical cases, the focus of the infection should be removed at operation, the exudate removed by suction, since it is toxic, and that the abdomen should be closed with drains put down only as far as the peritoneum to prevent the formation of abscess in the fascial planes.

DRAINAGE OF THE PERITONEAL CAVITY

Almost every investigator has been positive in the statement that it is impossible to drain the infected peritoneal cavity. Abdominal drainage was conceived first by Hippocrates for the relief of ascites. The simple plain metal cannula of Hippocrates was used with ornate variations by his followers for several centuries. Heister, in the eighteenth century, first inserted a wick into the cannula and noted the phenomenon of capillary drainage. In view of the success in removing ascitic fluid, illogically it was concluded that drainage of the toxic peritoneal content would cure the patient of peritonitis.

With the advance of surgery during the nineteenth century, there was a veritable orgy of fanciful devices for freely draining the abdominal cavity on almost any provocation. From 1830 to 1910 the majority of surgeons followed the doctrine of "drain all" (which was expressed as a consensus of opinion at the Paris Surgical Conference of 1911), although there were already a few dissenters from this thesis. Lawson Tait, at about that time, stated the more conservative dictum, "When in doubt, drain." W. J. Mayo, in 1929, suggested that this be changed to "When in doubt, don't drain." This paper pleads for an even more limited use of abdominal drainage in peritonitis.

The futility of drainage in peritonitis has been verified repeatedly by much experimental and clinical study. Delbet,[12] in 1889, reported his interesting studies on peritoneal drainage. He put a glass tube in the pelvic peritoneum. Within forty-eight hours fluids injected into the abdomen through another opening failed to escape through the first tube. After forty-eight hours the drains were completely walled off by omentum, intestines, and coagulum. He concluded that drainage of the general abdominal cavity was impossible.

Yates,[13] in 1905, arrived at similar conclusions in his monumental work, and found that all his drains were walled off and made water-tight within eight hours.

CLINICAL OBSERVATIONS AND CONCLUSIONS

These brief notes on the experimental studies of peritonitis must cause the surgeon to wonder whether or not the urge to drain freely is not a fetish which we have inherited from our patron saint Hippocrates and his illustrious followers. If we grant that, in the well walled-off intra-abdominal abscess, there is some justification for draining such a cavity, what other use has intra-abdominal drainage in peritonitis?

ADVANTAGES OF DRAINS

The advocates of draining an infected peritoneum cite the following arguments in favor of drains:

1. They drain the infected abdominal cavity. Do they? There is abundant experimental and clinical evidence to prove that within a very few hours the drain ceases to act other than as an intra-abdominal foreign body, which is walled off by adhesions of omentum, intestine, and coagulum.

2. They localize the infection. This is very problematic, unless the presence of such a foreign body becomes an exciting cause for a further localization which might not otherwise have existed.

3. They prevent secondary abscesses. The very nature of the pathologic changes of peritonitis complicated by a drain would discount this supposition. The author's personal observations indicate that the mere presence of an intra-abdominal drain has not decreased the incidence of secondary abscesses.

DISADVANTAGES OF DRAINS

The disadvantages of the intra-abdominal drainage are numerous:

1. Experimental and clinical evidence show that an intraperitoneal drain ceases to act as such after from four to six hours.[11,12,13]

2. The presence of a foreign body, such as a drain, has been proved to lower the natural immunity of the peritoneum against infections.[10,11] (This would indicate that the drain is a menace, rather than a help.)

3. Drainage causes a temporary loss of the normal *defensive* peritoneal fluids.

4. There is a longer and more stormy convalescence, because of the added intra-abdominal patho-

logic changes caused by the foreign body; resulting in partial obstruction, ileus, and increased peritonitis.

5. The incidence of infection in the wound is greater. An intra-abdominal drain through an infected wound must attract and harbor all the dependent suppuration of that abdominal wound. The profuse purulent discharge from such a drained wound arises primarily from suppuration in the abdominal wall, and not from within the abdominal cavity. The depths of such a drainage tract, therefore, collects suppuration from the abdominal wound, and hence aggravates the intra-abdominal infection surrounding the drain.

6. There is naturally a higher incidence of post-operative adhesions which later are the cause of most cases of acute intestinal obstruction.

7. There is a higher incidence of early and late postoperative hernia.

8. Pressure necrosis of the drain has been the cause of many fecal fistulae and fatal hemorrhages.

IS INTRA-ABDOMINAL DRAINAGE NECESSARY?

Does the clinical evidence show that intra-abdominal drainage is necessary?

The author's experience agrees with the observations of many others,[14, 15, 16, 17, 18] who have published their views accordingly. Dr. J. D. Dameron[18] of Stockton, California, was one of the first to express these views in an article published in 1914. Doctor Dameron is still of the same convictions.

For about ten years it has been the policy of the San Francisco Emergency Hospital Service to avoid all intra-abdominal drainage in cases of contaminations and infections of the peritoneal cavity. We now have a consecutive series of over 200 cases of perforated peptic ulcers so treated and reported.[19] Furthermore, in no instance have we drained the abdominal cavity in cases of severe injury with gross contaminations from the gastro-intestinal and genito-urinary tracts, as seen in gunshot and stab wounds. (In many of these patients, the wound has healed per primum and the patient has left the hospital within two weeks, following a remarkably smooth convalescence.) No longer, also, do we drain the pelvis after gynecological operations in which gross infection and contamination are obvious.

During the past five years the same principle has been applied to appendicitis, and only the chronic, well walled-off abscesses have been drained. The acute, the gangrenous, and the ruptured appendices now are removed, and the peritoneum is closed without drainage. We are convinced that patients so treated have the best chance of an uneventful convalescence. The abdominal wound and retroperitoneal tissues withstand infection and contamination poorly. Such wounds should be drained adequately down *to* the peritoneum only.

QUESTIONNAIRE REPLIES

We are submitting for reference the results obtained from a questionnaire answered by 121 recognized Pacific Coast surgeons. It is interesting that the opinions of different groups were essentially the same whether the surgeons were from the medical school faculties, metropolitan areas, or suburban districts. It is obvious from a study of such records that the majority of even the well trained surgeons today are not as yet willing to accept the major premises of this paper: that it is impracticable and inadvisable to drain the abdominal cavity in peritonitis.

The results from questionnaire received from 121 (F. A. C. S.) surgeons of recognized ability in various cities of the Pacific Coast follow:

PART A.—*Drainage of the Peritoneal Cavity*

GIVEN: A patient with a moderately severe, acute appendicitis and a fairly good general condition as regards toxemia, dehydration, etc.:

	REPLIES		
	Yes	*No*	*Ambiguous*
1. Do you drain the peritoneal cavity following appendectomy of			
a. A simple acute, non-gangrenous, non-perforated appendix	2	119	0
b. A gangrenous, non-perforated appendix?	26	88	7
c. A perforated appendix with			
(1) Early local peritonitis?	80	35	6
(2) Diffusing peritonitis?	104	13	4
(3) Late general peritonitis?	107	12	2
d. Localized abscess formation?	81	0	0
2. Do you consider any of the following as indication for drainage?			
a. Non-removable necrotic tissue?	96	17	7
b. Purulent peritoneal content	67	6	7
c. Oozing (blood) surface	49	58	14

	P. and/or I.	*Leave*	*Combination*
3. Do you "purse-string," invert, or leave the stump?	79	30	12

	Yes	*No*	*Ambiguous*
4. Do you peritonize raw surfaces?	105	10	6

	Penrose or Rubber Dam	*Hard Rubber Types*	*Miscellaneous, Gauze, Glass Tubes, etc.*
5. If you drain any of the above conditions			
a. What TYPE of drain do you use?	102	16	3

	Local	*Local and Pelvic*	*Multiple*	*Ambiguous*
b. What AREA do you drain?	55	37	15	14

	Yes	*No*	*Ambiguous*
c. Do you ever use Multiple Drains?	101	19	1

	FMO	*Operate*	*Ambiguous*
6. With a perforated appendix and diffusing peritonitis, do you			
a. Follow the Fowler-Murphy-Ochsner, delayed or non-operative, treatment			
b. Or OPERATE immediately?	10	94	17

PART B.—*Gunshot Wounds Perforating the Peritoneum*

	Yes	*No*	*Ambiguous*
Do you place a drain in the peritoneal cavity in the following groups of gunshot wounds:			
a. Peritoneum only perforated, NOT GUT?	11	66	6
b. Gastric or duodenal perforation?	28	46	11
c. Jejunal perforation?	32	41	10
d. Ileal perforation?	43	28	11
e. Colon perforation?	76	9	8

PART C.—*Extraperitoneal Drainage*

Do you drain the wound (extraperitoneally) as follows:			
a. With a clean wound?	8	98	8
b. With a contaminated wound?	89	16	16

CONCLUSIONS

1. The persistent and apparently increasing mortality from peritonitis needs very careful study with a view to standardization of treatment.

2. In peritonitis it is impossible to drain the abdominal cavity adequately.

3. Drainage probably aggravates or initiates the spread of infection.

4. Drainage encourages the formation of intra-abdominal adhesions and resultant obstructions.

5. Intra-abdominal drains prolong the healing of the wound, and encourage formation of both early and late ventral herniae.

6. Intra-abdominal drainage does not lessen the incidence of secondary abscesses.

7. Drains often are the initiating factor in the development of fecal fistulae and fatal hemorrhage.

8. Except for the chronic localized abscess, drainage of the infected or contaminated peritoneal cavity is very seldom indicated.

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DISCUSSION

John D. Dameron, M. D. (242 North Sutter Street, Stockton).—In his paper, Doctor Rhodes has given the pathology, the cause of peritonitis, and the percentage of the death rate.

Why do more persons die of appendicitis in the United States than in any other country? Very well has Doctor Rhodes brought this question out. There is no doubt that it is largely due to lack of experience in performing the proper toilet in the abdomen, following various ruptures of the abdominal viscera complicated with peritonitis. The very first thing that we must think of in a ruptured appendix is this: where has the fluid found its level—in the neighborhood of the appendix or in the pelvic cul-de-sac? This will entirely depend upon the position in which the patient has remained after the occurrence of the rupture. If he has been flat on his back, or on his right side with his right thigh flexed, you will find it in the lower right hepatic quadrant. If he has been up on his feet, or in the Fowler position, you will find it in the pelvic cul-de-sac, and there is where we find it nine times out of every ten. I have often been surprised at the amount of pus in the pelvic cul-de-sac that would have been absolutely overlooked unless thorough search for it had been made.

Doctor Rhodes refreshes our mind in regard to the inhibited movements of the bowels in peritonitis. When this does not occur in my cases after an operation, I administer opiates to bring about and maintain this condition for several days; and I have always found that the patient progresses more satisfactorily if not allowed to suffer from postoperative gas pains, thus giving nature a better chance to recuperate. In abdominal distention due to peritonitis, I have found that it is best controlled by hypodermics and hot applications. I never resort to colonic flushing or laxatives. Relaxation through hypnotics has proved most successful in my experience.

After rupture, the primary infection, whether it be streptococci or any other form of bacteria, subsides or, in other words, causes but little trouble when freed in the peritoneal cavity. This is probably due to immunization taking place, and is immediately followed by the bacterial flora of the bowels. I believe that if it were possible to close the mouth of the appendix just prior to its rupture, nature would take care of the contents spilt from the appendix into the abdominal cavity with nothing more grave following than a localized peritonitis or abscess.

I do not feel that it is necessary for me to comment on the pathological changes in peritonitis. Doctor Rhodes has given it from every scientific angle, so I rapidly pass over this part of his paper to clinical observations and conclusions. Do they drain the infected abdominl cavity? Yes, they drain it for about four hours—just at the time nature is doing its very best to reëstablish itself. The peritoneum has been wounded, the abdominal viscera has been manipulated, the patient has been subjected to an anesthetic, and every vital power has been exposed to, and is suffering from shock. No doubt you have noticed how much drainage you get from an abdomen in the first four hours, and how little in the following length of time. Do you realize that you have drained out the peritoneal fluid that is so full of leukocytes and so essential to repair.

I remember an incident: a surgeon operated on a ruptured appendix. He changed his dressing, and called me to see it. It was wet. He said, "Now what would you do with a thing like that?" I replied, referring to the serum and leukocytes, "I am afraid you left the gate open, and all the horses ran out." I cite this case to you for one thing only, and that is to demonstrate the fallacy of drains. There is no question but what you should remove all the infection that you possibly can at the primary operation. I have almost arrived at the conclusion that where all the serum in the abdominal cavity has to be removed with the infection that we should replace the same with one of the substitutes for serum that is now on the market. Especially so after long operations where the serum has been sacrificed by walling off with packs.

I do not believe in drainage following localized abscesses. I carefully wall them off and aspirate by suction, then freely open and remove as much of the sac as I deem advisable, cauterize the remaining portion of the sac with carbolic acid, and close the abdomen, and I have never had any bad results following; nature has always successfully cared for that. As far as I can remember, I have drained only one abdomen, and that was following a necrotic gall-bladder on a surgeon in Oakland; this was done entirely to avoid criticism by my confrères, should any serious consequence follow the closure procedure.

I do not believe that we have given the functions of different peritoneums the careful attention they deserve. Sometimes you open the abdomen and encounter a thin, almost spider-web sac, so frail that you can hardly readjust the same in closing the abdomen without leaving enlarged holes at the site of the needle puncture; while in other cases you have a peritoneum of entirely different texture and color, thick and strong, which reacts just as differently as it looks. I have had occasion to reopen abdomens shortly after

a laparotomy, and I have noticed that the thin peritoneum would not give the protection to the viscera that the more developed one did. There was less fluid present in this type of peritoneum and, likewise, more adhesions.

Then there is another side to it. The peritoneum in one case will not react to trauma normally; for instance, we may open into an abdomen, have a perfectly clean operation, and if we have reason to open that abdomen a few years afterward, we would be astonished at the amount of adhesions to the parietal peritoneum. And, on the other hand, we can do a great deal of manipulating of the contents of the sac with practically no adhesions. Why is this? As I have explained, the delicate one is subject to great trauma by manipulation, and then again, due to the lack of proper adjustment of the raw surfaces of the peritoneum in closing the abdomen. It has been my procedure that, when I opened the abdomen and found free pus accompanied by agglutination of the bowels, I did not separate the same, and no complications followed.

Here, we will say, is presented a ruptured appendix complicated with peritonitis; the patient is living, of course, or he would not be brought to the operating table. Under this condition how much better chance he will have to open the abdomen, remove the cause of infection and do a thorough cleansing, close up the abdomen, and give nature its chance. It is true that we still have infections extraperitoneal in the wound, and I often have been relieved when this happens, because I then realize that the peritoneum is taking care of whatever infection that may be left in the abdominal cavity down to the peritoneum or the deep fascia, and, to my surprise, at no time has the peritoneum ever given way under these conditions. In my early closures of the abdomen, in the face of peritonitis, I did have some abscesses of the cul-de-sac, and had to drain them through the rectum or the vagina. This was due to my faulty technique, which I have overcome by experience.

I have used every method to prevent infection of the external wound, but have never been able to counteract the same. I have long since ceased to put drains through the wound down to the peritoneum: I simply let it alone and watch the patient. If I were going to have infection in the external wound, it usually came on about the fourth day; the temperature would rise and I would immediately remove one or two of the most dependent sutures, and with the handle of a scalpel I would open up the lower end of the wound down to the deep fascia. In most of my cases this is all I ever have to do, and in a great number of them there is primary union.

Why did I stop drainage? I had never heard of it before. I think I had used every form of drain that was advocated at that time; none was satisfactory. The first thing that called it to my attention was how quick the drains became blocked off, and how I struggled to maintain drainage! I was not getting anywhere with this method. I knew of no other. Realizing that the abdominal viscera was bathed in serus fluid, I began to think: why not save it, why leave these bowels dry and subject them to adhesions, why not reserve this fluid?

This was in 1908 while I was superintendent of the San Joaquin General Hospital, and so strong were my convictions that the peritoneum would take care of the infection after removing the exciting cause and a perfect toilet of the abdomen, I felt confident that closure would be a safe procedure. I was thankful to find that the patient made a complete recovery, with the exception of external infections of the abdominal wound, and that was when I discovered that the peritoneum did not reopen from this infection although it had been closed with catgut.

The first time that I ever publicly endeavored to interest the profession in non-drainage of the abdomen was before the surgical section at the State Association meeting, which convened at Santa Barbara in 1911. On that occasion I was rather timid, and so was severely criticized.

Charles T. Sturgeon, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Rhodes has again called our attention to a subject which remains undecided; for no matter how many times it is discussed, surgeons continue to follow long-practiced procedures which they have found to be ideally suited to the individual case.

Doctor Rhodes is to be complimented in expressing his personal views on this much-discussed subject of drainage, especially because he does not voice the unanimous opinion of the medical profession which, with the laity, has in the past accepted drainage as an important procedure. The death of a patient where drainage has not been used, or has been inadequate, often leaves doubt in the minds of the laity that complete and proper care has not been exercised; whereas drainage, properly instituted, in fatal cases relieves the surgeon of this criticism.

Doctors Dameron and Rhodes and other pioneers on this problem of non-drainage will have to spend much time and energy to convince the profession that much of the drainage is unnecessary. It takes considerable courage to close without drainage an infected abdomen in which there is peritonitis.

I am in accordance with Doctor Rhodes' procedures, and in my own practice I am employing less drainage in infected cases. The first patients on whom we ceased to use drainage were those with infected pelvic disease. Shortly thereafter, we minimized the use of drainage in patients with intestinal anastomosis, cholecystogastrostomies, etc. We also, in most instances, have been closing the abdomen without drainage in patients with appendicitis where seropurulent fluid was present. Because the progress of these patients was satisfactory, we have closed without drainage nearly all cases of appendicitis including those with spreading peritonitis. Exceptions were made where there existed a well-walled-off abscess. It is our opinion that, in spreading peritonitis, drains are practically useless. It seems impossible to drain the peritoneal cavity in a patient with generalized peritonitis where the coils of intestines are adherent, usually concealing multiple small abscesses between these coils.

Our method of handling such cases is very similar to Doctor Rhodes' method:

1. Removal of the appendix, namely, the focus of infection.
2. Removal of all exudate by suction in order to avoid toxic absorption. (We feel that it is poor judgment to irrigate the peritoneal cavity in patients with general peritonitis.)
3. Closure of the abdomen, placing a small drain down to the peritoneum in order to prevent the formation of an abscess of the abdominal wall.

It is my opinion that any localized abscess in the peritoneal cavity should be treated by suction, followed by the insertion of drains. The use of hard rubber tubes or gauze has long since been discontinued; to us, the ideal method of drainage is the use of pieces of rubber dam loosely rolled.

I have enjoyed Doctor Rhodes' paper very much. It is indeed timely, and his remarks on drainage are excellent. I feel certain that less drainage will become an established surgical procedure as more surgeons become familiar with his methods, and experience the same satisfactory results.

Emmet Rixford, M. D. (1795 California Street, San Francisco).—It would seem that Doctor Rhodes, by his telling abstract of the literature of experimentation in this field, and by his clinical experience, has amply proved his thesis that drains, of no matter what form, do not drain the general peritoneal cavity; that drainage is worse than useless in general peritonitis.

In a clinical experience extending as student and practitioner through the entire history of our knowledge of appendicitis from the epoch-making papers of Talamon in Paris (1888) and Reginald Heber Fitz of Boston (1890), we have run the gamut of accepted practice in this field, from the early doctrine of draining in all cases, draining in perforative cases, then

draining only localized abscesses, then inserting drains only as far as the peritoneum, to draining not at all.

For a time we used rubber drains as routine, and had many fecal fistulae; but no fistula since the rubber tubes were discarded. We fortunately escaped hemorrhage from perforation of an artery by a rubber tube, but we were always careful not to put a drainage tube near any large artery.

Following Mikulicz, we used massive drains of gauze at one time—many yards of strips packed within a sheet of gauze, and a glorified capillary drain, but it was difficult to extract, and probably did a good deal of harm by setting up adhesions. In the earlier days, we had a good many hernias, some even in the McBurney incision where drains were used. Yet, as far as I have been able to determine, we had no cases of added infection by extraneous bacteria entering the peritoneum by way of drainage channels, causing peritonitis. I think this particular danger is much overrated. In recent years we have used drains but little in appendicitis, not at all in non-perforative cases, nor in cases of gangrene, nor of acute inflammation with bacterial penetration of the wall of the appendix when at operation the region is found to be flooded with opalescent fluid of syrupy consistency. But in cases where the appendix has really burst—by this I mean a sudden explosive bursting, discharging its contents into the peritoneum—and especially if a concretion has gotten away, I cannot bring myself to believe that it is not safer to put in a drain, if for no other purpose than providing a way out for infectious material.

In several cases of perforation in which it is well known that the peritoneum has a higher resistance to bacterial invasion than has the connective tissue of the abdominal wall, and in which we have inserted drains as far as the peritoneum, I have found afterward that the superficial wound had a direct connection through the peritoneum with the site of the appendix, or that it is difficult to be quite sure that, under such circumstances, it would not have been better at least to have left the peritoneum open, using perhaps a piece of rubber dam or a Penrose drain.

In localized abscess, the bacteria are either dead or in attenuated culture, else abscess would not occur. Here there is no object in draining more than to keep the peritoneal wound open for exit of fluids which are likely to reaccumulate after evacuation of the abscess.

As an example of the tendency of the peritoneum to wall off a foreign body, such as a drain, by means of fibrinous adhesions, I might cite the following: Not long since I had occasion to insert a drain through the vagina into the pelvis, because of soiling of that part of the peritoneum with contents of the colon. The patient died of peritonitis, and autopsy showed that there was no communication between the peritoneal cavity and the drainage sinus.

Doctor Rhodes is quite right in calling attention to the native resistance of the peritoneum to the intestinal flora. Much experimental work has been done in the effort to establish the mechanism of such. More recent work appears to show that the resistance of the peritoneum seems to depend very much on the ingress into its cavity of large numbers of histocytes, large voraciously phagocytic cells which follow the polymorphonuclear leukocytes, the first to be poured out after an insult to the peritoneum, whether mechanical or chemical, which histocytes reach a maximum number at about seventy-two hours.

While I would agree with Doctor Rhodes in this timely paper that, in general, drainage of the peritoneal cavity is a myth, and in most cases is not only useless but is capable of doing definite harm, producing adhesions which may later give rise to intestinal obstruction, still—and it may be a matter of long training or perhaps something akin to religion—I find it very hard not to put in a drain in case of colonic perforation. I am reminded of a case of a young woman under twenty, on whom I operated for appendicitis with beginning perforation, where I closed the wound without drainage. The girl died of peritonitis. Perhaps she might have lived if I had drained.

PHARYNGO-ESOPHAGEAL DIVERTICULUM, PULSION TYPE*

By Edward F. Ziegelman,† M. D.
San Francisco

Discussion *by Charles T. Sturgeon, M.D., Los Angeles; Leo Eloesser, M.D., San Francisco; Ernst Gehrels, M.D., San Francisco.*

DIVERTICULA of the esophagus are usually described as being either of two pathologic entities: the pulsion or the traction type.[1] This is the simplest classification. Some writers[2,3] describe the condition under more descriptive terms, according to etiology, location and embryology. Jackson and Shallow[4] report cases, and add to the above classification the congenital, juvenile and multiple type. For all practical purposes the simpler classification answers the need of the clinician.

TRACTION TYPE

The traction type, as its name implies, is one where some extra-esophageal structure, due to inflammation and adhesions, pulls upon the esophagus. In such a manner the diverticulum develops. It occurs as a rule on the anterior wall in the region of the tracheal bifurcation.[5] Adhesions to the mediastinal glands seem to be the usual cause, and such pathology must be considered in the development of this condition. A study of this form of diverticulum demonstrates that they are wide-mouthed, as a rule, possess no neck, and are composed of a pouch or sac varying in size and shape. They are not usually amenable to surgical interference.

PULSION TYPE

The pulsion type is more common, at least in the literature. It is probable that many of the traction forms occur, but go unrecognized, and this may account for the prevalent opinion that the pulsion type is more frequent. It was originally described by Mondière.[6] Rokitansky was the first to classify them as to their etiology. One of the pioneers in the study of this condition was Zenker. His observations were based upon postmortem findings; and the type is frequently described in the literature under his name.[7] The pathology demonstrates that it may be considered to be a hernia, and it is thus described by many.[8] It consists of a sac and a neck. Its walls are composed of mucous membrane and submucosa, and over this is spread a partial covering of muscle fibers. It is derived from the inferior constrictor, and occurs near the midline. Statistics seem to show that they are directed to the left side of the neck rather than to the right. The location is at the transition of the pharynx into the esophagus on its posterior wall. Many believe that it should be considered as a pharyngeal pouch, and describe it as such. (Fig. 1.)

The inferior constrictor of the pharynx in its lower portion is known as the crico pharyngeus. It is characterized by a gradual change in direction of its muscular fibers and this can be demonstrated

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

† Dr. Edward F. Ziegelman died on October 12, 1934.

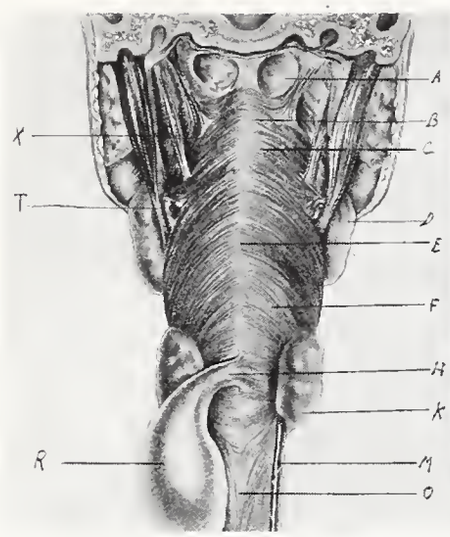


Fig. 1.

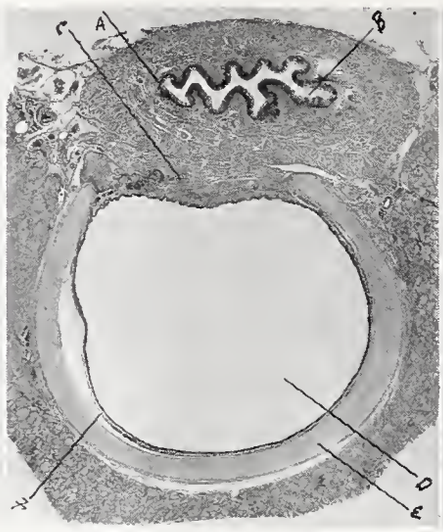


Fig. 2.

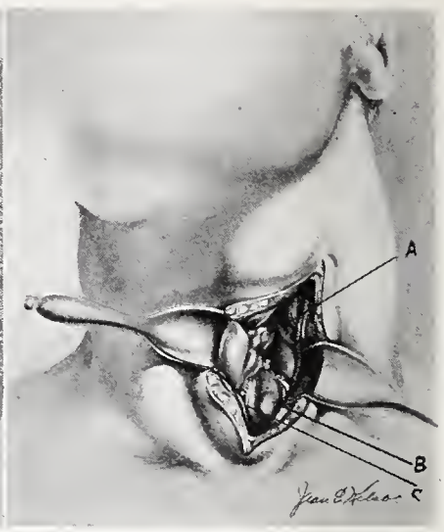


Fig. 3.

Fig. 1.—Photograph from a drawing of a dissection by the author and modified by the artist. It demonstrates at A the choana; B the superior constrictor; C the middle constrictor; D the submaxillary gland; E the median raphe; F the inferior constrictor; H the neck of a diverticulum; K the thyroid gland; M the recurrent laryngeal nerve; O the esophagus; R a diverticulum developing from the weak point the pharyngeal dimple; T the hyoid bone with its cornua; X the stylo pharnygeus muscle.

Fig. 2.—Photomicrograph cross section through trachea and esophagus. It clearly demonstrates the absence of cartilage in the posterior tracheal ring. A mucous membrane of esophagus; B the lumen of the esophagus; C connective tissue and muscle at posterior portion of tracheal ring; D lumen of the trachea; E the cartilage of tracheal ring; F mucous membrane of trachea.

Fig. 3.—Premastoid incision. A thyroid gland; B diverticulum; C recurrent laryngeal nerve.

on the cadaver. This transition is from fibers of an oblique to one of a transverse direction. In the median raphé, where the oblique fibers are replaced by the transverse, there develops a weakened area. Lahey has described it as the pharyngeal dimple. Others call it the Lainer Hackermann point.[9] (Fig. 1.)

The interesting hypothesis has been advanced, and appears plausible that, due to the rigid posterior cricoid area, the elasticity of this part of the pharyngo-esophageal structure has been lost. In contradistinction, the remaining portion of the anterior wall of the esophagus is in relation with the posterior tracheal wall. As is well known, this is fibrous tissue, since the cartilaginous rings are not closed in their posterior portion. (Fig. 2.) This anatomical peculiarity serves as a safety valve for any excess pressure that may be made upon the esophageal walls. In the crico pharyngeal area this does not exist. The cricoid is intact throughout. It has a firm posterior bony surface.

LOCATION OF ESOPHAGEAL DIVERTICULA

The literature states that fully 90 per cent of esophageal diverticula occur on the left side. No explanation of this peculiarity is given. From a study of many cadaver and postmortem examinations, the writer feels that it is explainable on an anatomic basis. The great vessels of the neck arise from the arch of the aorta on the left side. On the right side, the innominate artery gives off the common carotid and subclavian at a much higher level than the plane from which these vessels arise from the arch on the left side. In such manner, a vascular barrier is present to a greater degree on the right side than on the left. Assuming this to be so, it is very evident that a pouch will more readily be directed to the left than to the right. This would appear to be logical when it is recalled that the pouch must possess weight and hydrostatic power, since it serves as a reservoir for food and fluids.

Plummer[10] described the condition of esophageal diverticulum very completely, and his work has been a stimulus for others to do so. Since his original contribution on this subject much has been published in the literature. Stewart[11] reported two cases of esophageal myoma with the presence of a diverticulum.. The same writer states that subepithelial myoma of the intestines have been observed to occur with intestinal diverticula. Age seems to play an important rôle in the development of the pulsion type, for it is prone to occur after the fortieth year. It is more prevalent in men than in women, in the proportion of four to one.

In a letter by Lord Moynihan to "Surgery, Gynecology and Obstetrics"[12] he asks if, "in the interest of accuracy, he may be permitted to correct a few statements in the paper on "The Surgical Treatment and Management of Pharyngo-Oesophageal Diverticulum" by Doctor McEvers, on pages 525 to 532 of the October issue.

PHARYNGEAL DIVERTICULA

There is no such thing as a "pharyngo-esophageal" diverticulum. There are "pharyngeal" diverticula, and "esophageal" diverticula; those to which Doctor McEvers refers are pharyngeal. The name of Zenker must not be attached to these interesting sacs. They were first most accurately described and most perfectly illustrated by Ludlow in a letter to William Hunter in 1764. His specimen of a "preternatural dilation of, and bag formed in, the pharynx" (please note "pharynx"), is still perfectly preserved in the Hunterian Museum at Glasgow. Monro, Sir Charles Bell, Matthew Baillie, and others gave accurate descriptions of the condition. Doctor McEvers speaks of the "Lainer Hackermann point." It is Lainer, who was prosector at Graz, and Hackermann, now of

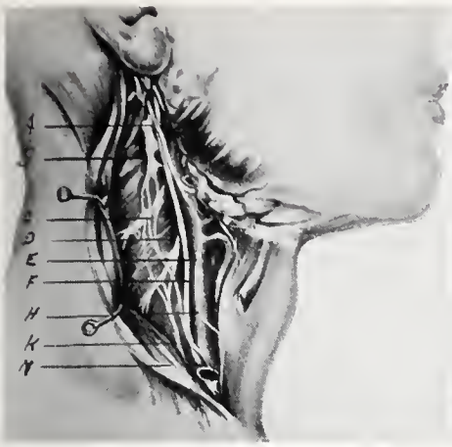


Fig. 4.

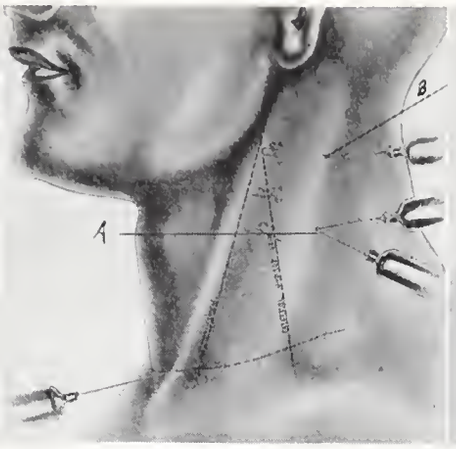


Fig. 5.

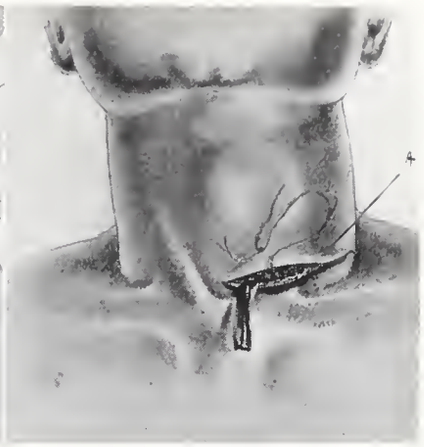


Fig. 6.

Fig. 4.—Photograph of drawing of a dissection by the author. It demonstrates the cervical nerves and other structures of the neck. A the hypoglossal nerve; B the second anterior cervical nerve; C the third cervical with ascending cervical nerve; D the scaleni muscles; E the descendens hypoglossi; F the vagus; H the carotid; K the phrenic; N the retracted sterno mastoid muscle.

Fig. 5.—Showing technique of cervical block anesthesia. A point of injection for third and fourth cervical nerves; B point of injection for second cervical nerve.

Fig. 6.—Closure of transverse incision with drainage.

Bremen, in whom interest centers. The "point," to which Doctor McEvers refers, is not a point but an area. The "Lainer Hackermann point" becomes, therefore, the "Lainer Hackermann area." It is not true that in this area the pharyngeal pouches originate. They arise above the sphincter formed by the cricopharyngeus muscle, and the Lainer Hackermann area is not of the slightest importance. These elementary truths were pointed out by me in a paper in the *Lancet* (1927, 1:1061), which unhappily has escaped Doctor McEvers' notice. In the final paragraph of this article, I say: "Few subjects in surgery are so littered with inaccurate references and incorrect names as this. I write not solely to call attention to the facts mentioned, but to encourage my American friends to perform the operation of resection of these pharyngeal pouches in one stage. If a surgeon is competent and has a perfect technique, there is really no need whatever for operations in two stages. I have operated upon fifteen cases (one on the right side), and have never had any difficulty in obtaining healing by first intention."

SYMPTOMS

The symptoms depend upon the size and extent of the pathology. Early in its development, very little is noticed by the patient. A feeling, as if a foreign body might be present, is frequently complained of, and a condition simulating a scratching in the throat is of frequent occurrence. As the diverticulum enlarges, more definite symptoms are noted, dysphagia playing a prominent part. This is probably due to the fact that the mouth of the diverticulum is wider and more directly in line with the axis of the pharynx than the normal opening of the esophagus, and food, therefore, passes into and distends the diverticulum. When full, it occupies the space between the vertebral column and esophagus. Indirectly it presses itself against the posterior tracheal wall, and this accounts for the presence of dyspnea as well. As the pouch enlarges, it is usually deflected to the left of the midline. (Fig. 1.) In such manner a swelling is formed in the lateral neck. This must not be confused with a unilateral or cystic enlargement of the thyroid. From this lateral neck swelling retained food and fluids can be frequently squeezed back into the mouth. This is an important diagnostic clinical observation made by most observers. Retention of food in the sac causes decomposition, and an unpleasant oral odor is the result. Regurgitation is frequent, both voluntary and involuntary. The patient prefers to eat slowly and alone, due to the embarrassment caused by this regurgitation. In time emaciation may develop, caused by difficulty in swallowing liquids and solids. The size and pressure of the diverticulum may cause more or less obstruction to the passage of material into the stomach. An irritable cough is quite common. This can be explained on the basis of irritation and traction of the recurrent laryngeal nerve. (Fig. 3.) Many writers describe other symptoms. This applies to the entire subject, not only as to symptomatology but the pathology, diagnosis and treatment as well. Lotheissen[13] has published a most complete and comprehensive article on this subject.

The diagnosis of the pulsion type, as a rule, is not difficult. A good clinical history leads one to suspect the pathology, and a failure to appreciate such a condition is invariably due to the patient not mentioning one or more of the cardinal symptoms. The presence of a neck-swelling, unilateral in type, should make one suspicious. This is especially true if it is accompanied with regurgitation; and if a gurgling sound can be determined, either with the normal ear or stethoscope, in the presence of such a lesion, the diagnosis is usually made. Corroboration with the esophagoscope and x-ray substantiates the diagnosis.[14] In the final analysis a good clinical history, with one or two of the above described symptoms, is pathognomonic of the presence of a pulsion type of esophageal diverticulum.

A differential diagnosis must be made from stricture, but this is not difficult. With barium, the opening through the stricture will be seen as

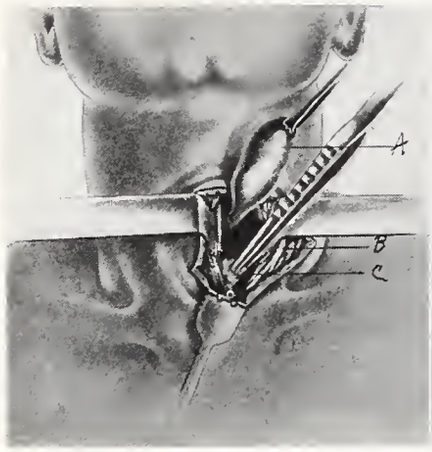


Fig. 7.

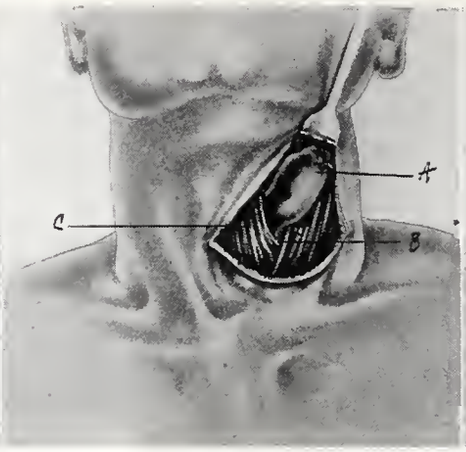


Fig. 8.

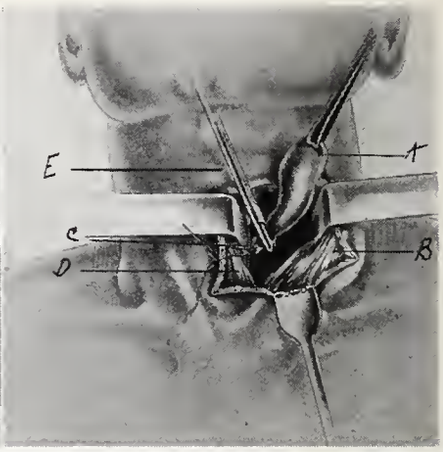


Fig. 9.

Fig. 7.—Showing diverticulum free with pack in its former location. A the diverticulum; B sterno mastoid retracted; C pack being placed in position.

Fig. 8.—Method of anchoring diverticulum at end of first stage. Notice it is anchored in an upward oblique direction. A the diverticulum; B sterno mastoid muscle; C prelaryngeal muscles.

Fig. 9.—Method of removing sac. A the diverticulum; B retracted sterno mastoid; C purse string suture in neck; D retracted prelaryngeal muscles; E clamp on neck of diverticulum.

a small line going directly into the remaining esophagus. In a diverticulum the barium tends to fill up the pouch first. It then overflows into the esophagus. The differential diagnosis from lateral lobe cystic thyroidal degeneration, as well as misplaced thyroidal tissue in the lateral neck, must always be kept in mind.

TREATMENT

The treatment is surgical. It has been an evolutionary development and many surgeons have contributed their ingenuity and skill to the perfection of the operative procedure. Notably Bevan,[1] Halstead,[6] C. H. Mayo,[16] Murphy,[17] Goldman,[18] Judd[19] and Lahey[20] have reported their surgical technique and results.

At the present time the treatment resolves itself into the teaching of two different schools of thought. One advocates the one-stage method, the other the two-stage. Babcock and Jackson[21] believe that the one-stage operation, through a transverse neck incision, is the method of choice. They use the esophagoscope to clean out and orientate the sac prior to, and during the operative procedure. They believe that with the utilization of the esophagoscope the danger of infection is at a minimum, and that they are able to accomplish the treatment in one-stage with perfect safety. Shallow and Clerf follow the same technique. Quartero,[22] likewise Grignani,[23] report a satisfactory result following the one-stage method without the use of the esophagoscope.

In 1917, Mosher[24] reported seven cases in which he had cut the common wall between the esophagus and diverticulum. This operation was carried out entirely by way of the esophagoscope. No external incision was made. He now advocates the two-stage operation of Lahey, using local anesthesia. In 1927, Imperatori[25] reported a method by which the sac was inverted endoscopically and ligated, and removed at the end of five to seven days by gentle traction. No external incision was made. He now advocates the Lahey technique.

Dr. R. D. McClure[26] reports a case with recovery, treated in the following manner. The diverticulum was dissected free and a catheter was passed into the pouch by way of the mouth. This was transfixed to the pouch with one stitch. The diverticulum was then drawn into the esophagus and a purse-string silk suture was placed at its base. This was reinforced by several fine silk sutures. A gauze drain was placed below the inversion site in case of leakage, and one rubber drain was placed to the site of inversion. He and his associate had planned to remove the sac the next day with a tonsil snare. This had to be modified, due to a marked edema of the inverted sac. Therefore, the upper part of the inverted sac was removed with scissors, allowing the remaining portion to be snared off down to its base.

Judd[19] and Lahey,[20] as well as most surgeons, advocate the two-stage method. Their argument is that it protects against the dangers of leakage and subsequent infection. It is made through a presternomastoid incision. The sac is freed, and anchored in an upward oblique direction for ten days, or until adhesions have formed, and it is then removed. (Figs. 7, 8 and 9.)

If postoperative infection should occur, it is usually a very serious complication. As the esophagus lies in the plane of the fascia which extends into the mediastinum (that is, between the vertebral column and trachea), a mediastinitis is very apt to be the result. Other complications to be feared are insufflation pneumonia, secondary hemorrhage, injury to the recurrent laryngeal nerve and a recurrence.

450 Sutter Street.

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DISCUSSION

Charles T. Sturgeon, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Ziegelman has covered the subject of pharyngo-esophageal diverticulum very well. There are only a few points which I wish to emphasize.

It is a misnomer to call these pouches esophageal diverticula, and they should be designated by their proper name. They are pharyngeal diverticula, and originate between the pharynx and the esophagus on the posterior wall of the pharynx above the cricopharyngeus muscle. Pulsion diverticula may occur in the esophagus, but generally they are situated at the lower end of the esophagus, near the cardia.

Many theories have been advanced as to the cause of pharyngeal diverticula, such as that mentioned by Doctor Ziegelman, *i. e.*, a weakness of the muscles at the junction of the oblique and the circular fibers. Jackson points out that, due to the incoördination of the cricopharyngeus muscle, which does not relax when the constrictor fibers contract, it causes great intrapharyngeal pressure. Others have stated that it is a developmental defect. I am of the opinion that the most logical explanation in our present knowledge is the one advanced by Judd, who noted that dimpling ordinarily appears in the mucosa at the point where pulsion diverticulum occurs. It is conceivable that such dimpling in these cases is more marked and assumes the form of a very small pouch, thus providing the proper "anlage" for development of the diverticulum. It is assumed that incoördination of the cricopharyngeus muscle, increased intrapharyngeal pressure, decreased elasticity of the tissues with increasing age, and the constant accumulation of material in the pouch would facilitate its development. However, these factors, in the absence of such a developmental anlage, would probably fail to produce pulsion diverticulum. Evidence in support of this hypothesis is presented by a case reported by Rush, Stingly and others, of a large congenital diverticulum which was found to be present at birth, and which arose from the posterior lateral wall of the pharynx at the level of the cricoid cartilage.

In a group of otolaryngologists the most interesting part of the discussion should be symptoms and diagnosis. The symptoms produced are very typical. They are dysphagia, regurgitation, gurgling noises in the throat on eating or speaking, or on pressure over the sac when it is distended with food. Two symptoms which are of especial interest to the laryngologists are hoarseness and cough. Many of these patients have a troublesome cough with expectoration of mucus. The hoarseness and cough are due to pressure on the recurrent laryngeal nerve, and these symptoms may be present before the onset of regurgitation and dysphagia. One of my patients gave a history of cough with expectoration of mucus, present for three years, before any symptoms of regurgitation and dysphagia were manifested. In a case of this type you can easily be excused for not making a correct diagnosis, but given a patient with cough, regurgitation and dysphagia, a roentgenological examination should be done which will in all instances reveal the sac, if present, and will also show whether it is located on the right or left side of the neck.

The roentgenological examination is also of great value in showing other pathology that may be present in the esophagus, such as a dilatation due to stricture and cardiospasm. It is at times difficult to differentiate between a pulsion diverticulum and a high dilatation of the esophagus. The fluoroscopic observation with barium may have to be repeated several times. The distinguishing factor between the two is that in pulsion diverticulum the sac empties from the top, while in dilatation of the esophagus the sac empties from the bottom.

It is unnecessary in all cases to make an esophagoscopic examination. This examination should be reserved for the cases in which there is a question of diagnosis.

The treatment is surgical. Dilatation has been recommended; however, I cannot see where dilatation would be of any benefit in view of the fact that there is nothing to dilate. Stretching the cricopharyngeus muscle is of no value except, if necessary, postoperatively. Nothing need be done for patients when the sac is small and causes very little disturbance; but when there is considerable difficulty in swallowing, regurgitation, etc., and even before much loss of weight occurs, the sac should be removed.

The surgical method most frequently used today is the two-stage procedure. The one-stage operation has been done successfully in many cases and is applicable when the sac is small, but it is not applicable when the sac is large as the danger of infection is too great.

Leo Eloesser, M. D., (490 Post Street, San Francisco).—A very few remarks might be added to Doctor Ziegelman's complete review of facts that permit of no discussion.

Esophageal traction diverticula may be caused by the adhesions of small tracheal cysts, or tracheal diverticula, which are seemingly not so rare. The cough of pulsion diverticula is not only due to nerve irritation—the cough is usually productive—due to more or less aspiration if the mass of food is secretion which overflows into or near the laryngeal entrance. A Levin tube passed through the nose into the stomach before operation and allowed to remain for four or five days afterward is helpful in assisting stomach to feed and to keep the esophagus completely at rest. It may, however, be difficult or impossible to pass the tube into the stomach without the help of an esophagoscope—a stiff tube or a bougie should never be used. They are likely to perforate the sac. I suppose that the two-stage operation is probably safer, especially in very old persons with a thin-walled sac. The Jackson-Babcock esophagoscopic method is good in the hands of a perfectly well-trained and careful endoscopist, otherwise esophagoscopy had better be foregone, for it is extremely easy to perforate these thin-walled sacs.

*

Ernst Gehrels, M. D. (490 Post Street, San Francisco).—From the surgical point of view I wish to amplify a few points.

1. It is advisable to operate these diverticula under local anesthesia. General anesthesia has the definite danger of aspiration of the contents of the sac during the operative manipulation. I use block anesthesia of the cervical plexus on the left side and infiltration of the line of incision of the skin.

2. It is hard to understand why the majority of publications still favor a longitudinal incision at the anterior edge of the sternocleidal muscle. I have found a transverse incision very satisfactory, even in the removal of very large diverticula. Cosmetically, of course, this is much better.

3. While the two-stage operation is still being chosen by the majority of surgeons, I favor the one-stage operation, unless the diverticulum is unusually large. Soiling during the operation can be avoided if one is careful. There is some danger of opening the sac inadvertently in the act of separating the diverticulum from the esophagus itself. At the end of the operation, a gauze pack in the lower angle of the wound will protect mediastinum sufficiently, in my opinion, in case the suture line should open. In using a two-stage procedure it is of great importance to free the diverticulum to the very neck. In the second stage the tissues are edematous and it is impossible to complete the dissection if it has been done incompletely before.

4. Danger of recurrence after a correctly done operation appears to be very small. In 225 one-stage operations compiled by Lotheisen, there were only three recurrences. The incidence of recurrence may be greater in the two-stage procedure, the excision of the sac often being less complete.

*

Doctor Ziegelman (Closing).—Pharyngenosis, which appears to affect the cricopharyngeus muscle, must be given consideration when the etiology of this lesion is being discussed. Pharyngo-esophageal diverticula are usually first seen by the laryngologist. The necessity for him to keep in mind a mental picture of this entity, with its early symptoms, is self-evident. It is a border-line lesion between the otolaryngologist, the peroral endoscopist and surgeon. A beautiful example of Dr. W. J. Mayo's definition of a specialist: "One who knows a little more, and more about something less and less." The method of treatment depends upon the experience of the attendant. I am convinced that those who have had great experience with the surgical anatomy of the lower neck, with its surgical application, as in the field of thyroid surgery or larynx, are better able to handle these lesions. I have seen this demonstrated on more than one occasion by my former associate, Dr. Thomas Joyce. The dangers of the combined operation have been so nicely mentioned by Doctor Eloesser. Unless one is an adept with the esophagoscope, perforation of the pouch may occur. This method has the advantage that it orientates the sac by transillumination. It lessens the danger of injury to contiguous structures, with subsequent complications, such as mediastinitis, hemorrhage and recurrent paralysis. Any procedure that minimizes such complications should be accepted. The two-stage method seems to accomplish this. When the specialty of peroral endoscopy has developed to a more uniform strata of experience and skill as manifested by Jackson, Mosher and others, the combined method may supersede the two-stage technique. I am inclined to believe that such a condition will occur, for the specialty of peroral endoscopy is a fertile field for young men with good vision, as shown by the recent report of Vinson on one thousand carcinomas of the esophagus.

PHYSIOTHERAPY AND OCCUPATIONAL THERAPY*

By Ione Pinney, M. D.
Stockton

Discussion *by Charles Lewis Allen, M.D., Los Angeles; C. W. Grady, M.D., Palo Alto; T. H. Stice, M.D., Imola.*

ALL forms of physiotherapy are not applicable in the treatment of the mentally ill because of lack of coöperation on the patient's part. The two physical measures of greatest value and most extensively used are hydrotherapy and occupational therapy.

Hydrotherapy, which is the use of water as a remedial agent, has been recognized as a method of treatment since the time of Hippocrates. While of late years efforts have been made to scientifically demonstrate its usefulness, much remains to be proved. In the treatment of mental cases, its use may often be said to be empirical. Hydrotherapy has proved of great value to the insane, and was first used in such cases over a hundred years ago in France. In England, in 1796, the surgeon, James Currie, treated maniacal patients successfully with cold baths. About ninety years ago Dr. Isaac Ray advocated use of prolonged neutral baths to produce sleep in nervous and mental affections. Today, every hospital for the care of mental cases makes use of some form of hydrotherapy, and many are well equipped with apparatus such as cabinets, tubs, and sprays.

REASONS FOR HYDROTHERAPY

The scientific application of hydrotherapy is based upon the physiological effects of heat and cold, plus, in some cases, friction and pressure. Heat and cold bring about metabolic changes in the tissues. Rubner has demonstrated that baths of five minutes' duration or less, may, according to their temperature, radically modify metabolism, as proved by the alteration in the amount of O absorbed and CO_2 given off in respiration. A

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cold douche increases greatly the oxidation of the body, a douche of 60.8 degrees Fahrenheit increasing by about 50 per cent the weight of O inspired and CO_2 expired. The increased metabolism is said to persist for an hour or more after the douche. The effect is probably largely due to a reflex excited by the cold water falling on the skin. The aim, however, therapeutically, is the establishment of what is called a "physiological reaction," which results in the amelioration of pathological symptoms. It is thought that the physical basis of such a reaction may be metabolic changes, and that they may be apprehended by making use of direct or indirect calorimetry. It is known that the sedative bath (95 degrees Fahrenheit) has no effect upon metabolism; whereas, with higher temperatures, metabolism is said to again increase, possibly because the tissue cells are warmed and their activities accelerated. Rubner found that in a hot bath (111.2 degrees Fahrenheit) there was a marked increase in respiratory movement and in the gas exchange. Hinsdale states that short cold shower baths increase heat elimination, but claims that cold *per se* reduces the oxidizing capacity of animal tissues, and that warmed tissues have a much higher rate of oxidation. If we consider that the increase in weight of O and CO_2 exchanged, following the cold douche mentioned by Rubner, is a secondary effect of cold, then we see wherein the statements agree. Some of the physiological effects of cold are: increased vigor, increase of red cells and diminution of leukocytes, slower but more vigorous heart action, temporary acceleration of respiration followed by slow, full, deep respiration, and a rise of blood pressure. In the application of heat we must recognize that, while there is at some stages an increase in metabolism, the mechanism, resulting from heat loss where cold is applied, is lacking. If when heat is applied evaporation is prevented, the body temperature will rise and may continue to rise after the bath, requiring an hour or two to return to normal. Hot baths promote sweating, diminish the output of urine, increase blood pressure, increase respiration and the pulse rate, and are said to excite the nerve centers. The secondary effects are sedative sometimes to the point of collapse. When heat is applied so as to obtain the desired "physiological reaction," metabolism is enhanced and elimination of various poisons and toxins augmented. Fox claims that the power of response of tissues to applications of heat and cold, and the production of secondary consequences in the entire organism, are the whole key to hydrotherapy. It must be recognized that the reaction is not always the same in any given individual, and that in every case there is a point at which heat or cold ceases to evoke a healthy reaction.

CONTINUOUS HEAT PACKS

The continuous bath and the neutral sheet pack are of most use in caring for mental cases. Both are indicated in the treatment of the manic phase of manic-depressive psychoses and in the disturbed dementia praecox. The continuous bath permits greater freedom of movement, and the patient can be kept in the bath all day or longer if desired. The temperature of the water should be kept at 95 or 96 degrees Fahrenheit, because higher temperatures (even 98 degrees Fahrenheit) tend to increase respiratory movements and entail a strain on hearts that may already be overtaxed. At 95 degrees Fahrenheit there is less likely to be an appreciable rise in the blood pressure. The results obtained are an improvement in the skin's activity, with some increase in elimination of poisons and sedation, so that the maximum of rest, a very necessary condition, is obtained. Patients that are wearing themselves out physically, and who respond poorly to sedatives, usually do well in continuous tub baths. Besides the manic and the excited praecox, restless and confused arteriosclerotic cases, alcoholic psychoses, and drug addicts, some paretics, and a few selected cases of epilepsy are the types that usually respond nicely to continuous tub baths. Mental patients who, because of poor reactions, cannot remain in the tub more than thirty or forty minutes, seldom benefit from such treatment. The best results are obtained in cases where the patients remain two to four hours in the tub.

NEUTRAL PACKS

Neutral packs have a sedative effect in hyperactive cases when the packs are repeated frequently throughout the day, provided the patient is not restless while in them. If a patient thrashes about continually, he will only wear himself out and bring on an undesirable reaction. The daily neutral pack of forty-five minutes to one hour, followed by the spray, induces a general tonic effect. The temperature of the water from which the sheets are wrung should be at least 98 degrees (preferably around 110 degrees), because in mental cases the stimulating reaction produced by cold is seldom desired. Excited patients do not need the stimulation, and depressed mental patients fail to react well to cold applications. To obtain the best results the patient should be comfortably warm before the pack is applied, and it sometimes is necessary to give a warm bath or a short cabinet treatment first. The reaction to the heat abstraction which occurs during the first few minutes in pack is thus lessened and the sedative action more prompt. A slight rise of body temperature occurs and a sense of warmth, drowsiness, and sleep are the results. The patient may be left in pack from forty-five minutes to two hours, but if heat loss is prevented too long, the patient perspires freely, respiration and the pulse rate are increased, and the face flushes. When such symptoms occur, the neutral stage of the sheet pack is past, and unless we particularly desire to increase elimination the patient should be removed from pack and put under the spray. All packs should be followed by a short application of cold in the form of sprays, douches, or affusion, by which means we may stimulate metabolic changes. Such an application should start at 100 degrees, rise to 110 degrees, and be lowered to 97 degrees for excited types, and to between 80 and 90 degrees for those who need stimulating. Three minutes is long enough for the entire ap-

plication, and the temperature for mental cases should never be dropped below 78 degrees Fahrenheit. Neutral packs are of value in all cases except those with high blood pressure, skin lesions, seniles, paretics, and excited mental defectives. The latter are inclined to resist packs. Epileptics, from the standpoint of elimination and general toning up, are safer treated by packs than by continuous baths. Depressed patients who react poorly can be greatly improved by intelligent handling in packs, gradually bringing about the stimulation that their bodies need.

CABINET TREATMENTS

Cabinet treatments, either steam or electric, are useful in mental cases where elimination especially needs stimulating, such as alcoholics or the obese, and in bringing about body warmth in the poorly nourished, retarded cases. The temperatures used are around 130 degrees for about ten to fifteen minutes in the first types, and 90 to 95 degrees for six or seven minutes in the last type mentioned.

HYDROTHERAPEUTIC TREATMENT OF THE PSYCHOSES

The hydrotherapeutic treatment of the psychoses outlined is based upon sixteen years of experience. For the past eight years I have insisted upon continuous baths being kept at 94 to 96 degrees Fahrenheit, and have had only one case that bordered upon collapse. Last year, in ten months, some seventy women patients received 2,450 continuous baths. The average duration per bath would run above two hours. Some were kept in tub for seven or eight hours daily, reducing the time as they improved. In addition to neutral packs given to chronic cases on the wards during disturbed periods, the women's hydrotherapy department, which is part of the receiving service, last year gave 3,621 neutral packs and sprays, 1,382 cabinet treatments, 172 shower baths, 25 salt glows, and 24 fomentations.

In the treatment of the psychoneurotic case, any form of physiotherapy may be used that is indicated and meets with the patient's approval. Massage and passive gymnastics have no special place in the treatment of the nervous mental case. Electrotherapy, according to some authorities, does not fall under the head of physiotherapy. Its specific uses in mental cases are in the field of diathermy for paresis, and roentgen-ray treatment for the purpose of sterilization.

OCCUPATIONAL THERAPY

Occupational therapy is a very old method of treatment. The Egyptians, when they built temples dedicated to Saturn in 200 B. C., recognized the benefit of "pleasurable occupation," and Galen in the year 172 A. D. wrote, "Employment is nature's best physician, and essential to human happiness." In 1791 the insane in France were liberated from their chains and put to work at normal occupations. In this country, in 1798, Dr. Benjamin Rush of Philadelphia began to use occupational therapy when he put groups of mental patients to work—the women at sewing, and the men at farming and carpentry, and furnished out-of-doors amusement for others.

Occupational therapy applied to mental cases becomes the main highway over which they travel back to a readjusted life in their communities. By its use mental and physical deterioration is either prevented, lessened, or delayed. Kraepelin stated, "Occupation alone can preserve, by exercise, the capabilities which still remain and prevent . . . wholly sinking into dulness." The occupational therapist must understand the crafts, and know how to apply them to the various types of mental cases. Awakening of interest, sustained effort and attention, replacement of morbid ideas with healthy ones, and establishing mental and motor control and coördination, are results sought and obtained in the mental sphere; whereas, improvement of individual and group morale, and opportunities for social adaptation in work and recreation, are developed in the social field. Physical training, which requires the active participation of the patient, and recreation, are, with the crafts, the tools used to obtain desired results. Habit-training must be instituted for those whose habits are disorganized. Such training requires much patience and persistence, but its results are worth while from the rehabilitation and economic standpoint.

In our state hospitals the occupational therapy department is well developed, and recognized as a valuable therapeutic agent. The classes for men and women are separate, but all social activities bring them together under as normal circumstances as possible.

Stockton State Hospital.

DISCUSSION

CHARLES LEWIS ALLEN, M. D. (214 South Lafayette Park Place, Los Angeles).—Hydrotherapy has been used more or less in the treatment of the insane since antiquity, though at one time it was applied as a disciplinary and punitive measure, rather than therapeutically.

It is only of recent decades, however, that it has become a routine practice in the psychiatric hospitals of the United States.

In a psychiatric experience of over forty years, the introduction of water treatment by the bath and pack, as also by hyperdermoclysis of salt solution accompanied, when needed, by glucose intravenously, has impressed me as the greatest therapeutic advance in our specialty, with the possible exception of the newer antisyphilitic methods.

The continuous bath and the pack reduce excitement and favor sleep, in the majority of cases, and the rightly dreaded "acute delirium" presents now a much more favorable prognosis, since we have come to regard its symptoms as due chiefly to dehydration and acidosis, to be handled by salt infusions and glucose—measures which seem almost specific here.

However, hydrotherapy is not a cure-all. Some patients are not relieved by it; and there are not a few contraindications, as Doctor Pinney has been careful to mention.

The continuous bath should be, of course, in charge of an experienced person, the patient under constant observation, and the temperature of the water be frequently noted, since the best thermoregulator may sometimes go wrong. On this account, also, it is held that any cover preventing the immediate removal of the patient from the tub should be avoided. Epileptics and paretics subject to seizures should be strictly watched.

While the tepid or neutral pack is extremely valuable and requires no special apparatus, it is not tolerated for an indefinite period and should be used with caution in those having circulatory disturbances, and avoided in those who are frightened by it or persistently resist and struggle to get out of it. It has seemed to me that in institutions in which every kind of mechanical restraint is strictly forbidden, there is a tendency to make too free use of this "therapeutic restraint," which may have disastrous consequences.

The hot cabinet, followed by a douche regulated as to temperature and pressure, is an important measure, but finds its chief place with the quiet and convalescent patients, especially those of neurasthenic type and those whose nutritive processes need stimulation. It is usually contraindicated in disturbed and delusional patients.

Occupational therapy is no new thing, but has been used in institutions for an indefinite period. Ability to keep a large percentage of its patients occupied has always marked a well-managed hospital. However, the occupation furnished the patients was formerly almost exclusively that of the house, kitchens and laundry indoors, and of the farm and garden outdoors.

The newer mechanical and artistic shopwork of the occupational therapy rooms, if made sufficiently interesting, may attract many persons, especially those who have never been accustomed to do what they regard as menial work and beneath their dignity.

Here everything depends upon the experience, enthusiasm, skill and tact of those in charge of the work. It often takes considerable ingenuity to get the patients to work, and many persistently refuse.

All appearance of compulsion should be avoided, but there is nothing worse for a chronic patient than sitting idle about the hall all day.

Doctor Pinney has given us an interesting, instructive and well-balanced paper, which should reach not only the specialist but also the general practitioner, and should encourage the more extended use of the physical measures of treatment which have been too much neglected in our country.

C. W. Grady, M.D. (Veterans' Administration Facility, Palo Alto).—Far too often physiotherapeutic measures, especially hydrotherapy, are used in a routine manner with little understanding of the rationale involved. Doctor Pinney's exposition of the physiological processes involved in the application of various forms of hydrotherapy is, therefore, especially valuable. Failure to obtain satisfactory results from use of the continuous tub may sometimes be due to too brief applications. While it is understood that the condition of the patient must at all times be considered, this writer has noted with agreeable surprise that many patients remain in perfectly satisfactory condition during a treatment of fifteen to twenty hours, sleeping and taking nourishment regularly throughout, being removed only when it is necessary to evacuate the bowels. It is also interesting to note that many patients, especially manics who have been subject to recurrent attacks of hyperactivity, have developed a certain amount of insight, and appreciate the relief to be obtained from continuous bath therapy and will voluntarily ask that it be given them at the onset of the attack.

As the doctor has pointed out, hydrotherapy is a measure not easily dispensed with. More stress might be placed upon the psychotherapeutic value of the various methods of electrotherapy, particularly in the various aspects of the neuroses. Neuroses are real disabilities, many times more disabling and nearly always less amenable to treatment than actual physical ailments. Such measures as diathermy, high frequency, ultra-violet ray, and sinusoidal wave, offer a form of treatment which the neurotic is able to see and appreciate. Such treatments, given along with positive and assuring advice as to what is expected to be accomplished, are of great help.

Much has been written as to the value of occupational therapy. It cannot be emphasized too strongly, not only with respect to the patient, but to those who are caring for him. From the patient's standpoint, occupation is the means of making extensive institutional life bearable.

From the standpoint of a State-supported institution, the economic value is great. In whatever degree a patient has been able to care for himself, by so much may the personnel be reduced. In many institutions, not only is much of the labor of upkeep done as an occupational therapy project, but a large portion of foodstuffs are produced as well.

T. H. Stice, M.D. (Napa State Hospital, Imola).—I was very much interested in Doctor Pinney's paper on physiotherapy and occupational therapy.

In 1905 and 1906, articles began to appear in some of the leading medical journals regarding the effect of hydrotherapy upon the insane. We had not been doing any hydrotherapy work in this State at that time, and after having read a number of these articles setting forth some of the results claimed by those hospitals in the East who were trying out the different forms of baths, I became much interested, and made an effort to get some sort of equipment in the Napa State Hospital, where I was then employed. As you all know, to get a thing of that kind for State hospital work, especially one that has not been tried out, is a very slow procedure.

In the meantime, I improvised two continuous baths from ordinary bath tubs by putting a hammock in the tub, with an outlet near the top; and with this improvised make-up, made a number of experiments and found that, with the disturbed manic cases, I got very surprising results.

I think at that time, so far as I knew, I was probably one of the first in the State institutions to make such experiments. My results were so satisfactory and so encouraging, especially with the acutely disturbed patients, that I also had a crude mixing chamber added to my equipment, so as to keep the water a more even temperature and lessen to a great extent the possibility of an accident from scalding.

It was not many months until the other State institutions for the insane learned of our experiments at the Napa State Hospital, and a number of doctors came over to see the actual operation and to learn as much as possible about what we were able to accomplish. Everybody became interested in the results obtained, and it was with concerted effort and concerted demands of the medical staffs of the various hospitals that we finally induced the Lunacy Commission to assist us in providing funds for equipments for the different institutions.

Today we wonder how it was possible for us to have gone as long as we did without such equipment, as the outfit has gradually been improved upon so that it is perfectly safe. It is very reliable as to maintaining an even temperature, and there is practically no danger of burning a patient or giving shock by getting a poor mixture of hot and cold water.

By the use of hydrotherapy, as outlined by Doctor Pinney in her paper, we are able to quiet these noisy and disturbed patients without having to resort to the hypnotics, which are more or less harmful in such cases, owing to the fact that they do cause more or less confusion from their after-effects. A very fortunate thing regarding the use of hydrotherapy is that as a general thing the patients, however violent they may be, after having had one such treatment are no longer dreading them, but in fact enjoy the treatments. It is very comforting to go into the pack room, where probably twenty-five or thirty patients are all in the packs, and find that over half of them are actually asleep. After all, any treatment that will quiet the patient to the extent that will cause a natural sleep is always very beneficial, and after you have

begun to induce natural sleep your patient has begun to improve; and this is the beginning of allayed excitement and putting the patient more nearly in a normal physiological condition, so far as controlling the mind is concerned.

I notice that Doctor Pinney advises that the temperature of the continuous bath be kept between 95 and 96 degrees Fahrenheit, and I think, from my experience, that she is absolutely correct. At first, in the use of these baths we were taught that they should be kept at blood temperature; but it was afterward learned that such temperature was a strain on the heart, and that the patient could not be kept in the bath long enough to get as good results as could be obtained by a lower temperature. I think it is conceded by everyone who is now using the continuous baths that 96 degrees is about the right temperature.

I have often been asked if in arteriosclerotic cases, and with patients having any kind of heart trouble, it were not exceedingly dangerous to put them in either the blanket pack or the continuous bath. I am glad to say that in many years' experience with these cases it was very seldom indeed that I saw any patients who had to be taken out of the bath on account of the strain on the heart, provided the water had been set at the proper temperature. In the hospitals of today we have only those that are thoroughly trained in the use of these baths, who watch their temperatures carefully, and who know what to expect, should anything go wrong; and for that reason our nurses seldom make mistakes. They are taught that they must be exceedingly careful, and that the temperature must be carefully scrutinized before the beginning of every bath, so that no possible accident can occur. During the past year we have averaged over 58,000 hydrotherapy treatments per month, and when I tell you that in the administering of that large number we have not had one single accident, it will demonstrate to you what I mean by providing "trained people" to give these baths.

Fortunately for those who are specializing in psychiatry we are constantly learning more regarding the use of hydrotherapy. A very important thing is the fact that our hydrotherapists, who are doing this work under the direction of the doctors, learn to individualize, and so some patients take kindly to one kind of treatment, while others with similar afflictions, do not, and it is important that our hydrotherapists should be able to distinguish the difference and to call the attention of the doctors to these things in order that the patients can be given such baths as they respond to most readily.

Occupational Therapy.—Doctor Pinney has given a very concise and a very clear outline of the use of occupational therapy. We who are doing hospital work realize its very great importance, since it is really the beginning of our rehabilitation and readjustment of the mental cases. We do not accomplish much in occupational therapy until after the manic state has been passed and the confusional state cleared up to the point of attracting and holding the attention of the patient.

The next thing I think of great importance is again individualizing the patients, to learn what each one in particular might most readily be interested in. If you attempt to use occupational therapy along the lines where the patient is not at all interested, you do not get the results by any means that is obtained when you have found something the patient is actually interested in doing.

It is very remarkable in some of these patients as to how far they can be led away from their imaginary troubles, and their minds diverted along lines that prevent their worrying.

Not only is occupational therapy a very important adjunct in our treatment of these cases, but I have seen many patients with dementia precox who have been trained to that extent that they can more readily adjust themselves to outside conditions, and ofttimes later earn a livelihood from what they have been taught while in the hospital.

GONORRHEAL ARTHRITIS—ITS TREATMENT BY ELECTROPYREXIA*

By Rodney F. Atsatt, M. D.
and
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Discussion *by A. Elmer Belt, Los Angeles; J. S. Hibben, M. D., Pasadena; Clark M. Johnson, M. D., San Francisco; Norman Epstein, M. D., San Francisco.*

THE "cleansing fire" of electrically generated heat in the form of hyperpyrexia has opened up a new avenue in the treatment of one of our most discouraging and chronic diseases, namely, the arthritic manifestations of gonorrhea.

GONORRHEAL ARTHRITIS

Gonorrheal rheumatism is the most common of the systemic results of this infection, and according to Jeck [1] has an incidence of from 1 to 3 per cent. The several types of arthritis are the serous, the serofibrinous, the rare empyemic or purulent, and, the most important, the phlegmonous. Many remedies have been suggested and used in the treatment of this complication; but by their very multiplicity they announce their ineffectiveness. Stripping of the seminal vesicles, and a rigorous attack on the cervix and associated glands are the most universally accepted methods of allaying the focal infection. Surgical methods are also employed at times. Nonspecific protein therapy, such as typhoid vaccine intravenously, and milk, aolan and omnadin subcutaneously, has been found of some value. Specific vaccine and serums have also been used. However, none of these methods have given the striking results which one desires in the treatment of a specific disease.

TREATMENT OF GONORRHEA BY ELECTROPYREXIA

The rationale of the treatment of gonorrhea by electropyrexia is based on the fact that the gonococcus is relatively thermolabile, is easily killed *in vitro* by slightly increased temperatures, and probably even more easily affected *in vivo* by the combination of heat and immunologic factors. Warren and Wilson [2] found that, of fourteen female patients with positive smears from salpingitis or cervicitis, or both, who received adequate treatment with hyperthermia, 71 per cent showed consistently negative smears, indicating an apparent change in the status of their localized infection. Bishop, Horton and Warren [3] reported the use of hyperpyrexia in the treatment of nine cases of gonorrheal arthritis with excellent response, and thus we were led to try this method of treatment.

APPARATUS USED

In our experience, four pieces of apparatus are essential in the production of artificial fever. The first is a rugged diathermy machine, the second

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is a suitable set of electrodes, the third is a hot-air cabinet, and the fourth is an electric thermometer.

The production of a satisfactory high frequency current requires a diathermy unit which will deliver 6,000 Ma. of smooth current, easily regulated in small gradations. It should be capable of maintaining this delivery for two to three hours without signs of an overload.

The hot-air cabinet is easily constructed out of celotex panels set in a wooden frame, insulated by a blanket covering. The one essential requirement is that it be spacious enough to allow the patient to flex his knees without restriction, and without danger of burns from the electric heating lights. We have found 2.6 x 2.0 x 6.6 to be the ideal dimensions. The head-end is enclosed and insulated by rubber sheet and blanket-drops, to be tucked in about the patient's neck. The heat is furnished by ten 60-watt carbon filament lamps. The optimum air temperature in the cabinet has been found to be 120 to 140 degrees, when the diathermic current is turned on, and from 140 to 160 degrees Fahrenheit when the current is off and it is desired to hold the temperature of the patient. This is well tolerated by the patient and is controlled by thermo-regulator. A shallow pan of water, with considerable evaporating surface, is suspended inside the cabinet to increase the humidity and thus reduce the heat loss from sweat evaporation. The cabinet is swung from the ceiling by means of ropes and pulleys for ease in manipulation.

For electrodes, we formerly used the Neyman type, but later found that a simple unfenestrated sheet of block tin, gauge No. 28, mounted on a three-eighths sponge-rubber backing, applied over a one-quarter inch absorbent pad moistened in normal saline, to be more satisfactory. This interposition of the wet pad requires somewhat higher milliamperage, but we feel that it is far safer than the bare tin. Only one slight burn has resulted as yet in a series of two hundred and fifty treatments, and the patient seldom complains of, nor is the treatment interrupted for "hot spots." The electrodes are of similar shape to the Neyman type, and are applied in a similar manner, by means of a canvas corset.

The fourth piece of apparatus, which is of considerable value, is the electric pyrometer or thermometer for indicating the rectal temperature. It consists of a delicate thermo-couple for insertion into the rectum, and a sensitive galvanometer so designed and calibrated that the body temperature may be read directly on the scale to an accuracy of two-tenths of a degree.

TECHNIQUE

The details of technique are difficult of adequate explanation, for so much of one's success depends upon a nicety of judgment, which is acquired only by experience. Following the suggestion of Warren and Wilson, we have used preliminary sedatives, formerly consisting of bromids and barbital, followed by chloral hydrate, at the beginning of the treatment. Later we employed morphin and scopolamin, but found some difficulty with respiratory embarrassment. At present we are using Dilaudid 1/32 grain scopolamin 1/100, given about twenty minutes after the beginning of the treatment, thus allowing approximately forty minutes of complete consciousness for the discovery of hot spots and for other adjustments for the patient's comfort. We feel that this narcosis is essential not only for the patient's comfort, but also for his safety, inasmuch as restlessness is a very important factor in the production of burns. We further feel that all points of potential irritation will appear within the forty-minute lag period, if burns are to result, provided the patient remains quiet during the remainder of his treatment. As the narcosis is only relatively deep, actually only a light twilight sleep, several procedures may be employed to reduce the discomfort of the patient. The air about the patient's face is kept in motion by an electric fan, iced towels are placed on the patient's head, cool dry pillows are frequently exchanged for the hot moist ones, and frequent drinks of uniced water are given. Some patients are quite restless, even with the narcotic, and the operator's ingenuity is often taxed considerably to quiet and reassure the nervous patient. It is absolutely essential that the technician appear calm and self-assured.

The pulse, temperature, and respiration should be carefully recorded every fifteen minutes during the early stages, and oftener as the treatment progresses. If the subject becomes nauseated or extremely exhausted, all active heat should be turned off. Indications of circulatory collapse, such as intense facial cyanosis, circumoral pallor, rapidly increasing pulse rate or markedly falling blood pressure, are sufficient points of evidence on which to terminate the treatment. Needless to say, no treatment is ever started without careful preliminary physical examination, and severe cardiac disturbances, marked arteriosclerosis and nephritis are usually excluded from this procedure.

The Electrical Apparatus Is Used as Follows.—The plugs, marked for identification, are connected to the diathermy unit, and the electrodes are applied over the moistened pads by means of the snugly fitting corset. On an initial treatment, a gradually increasing amount of current is released to the electrodes, the intensity depending on the size of the individual and the type of temperature curve desired. On subsequent treatments, however, the optimum milliamperage is known, and the adequate amount which will, together with the cabinet heat, give a constant rise of 0.8 to 1.0 degree every fifteen minutes, is selected. In general, the faster the rise can be obtained the less fatigue will the patient have to endure; but one should be guided always by the changes in pulse rate and circulation, and usually a rise of more than 0.8 to 1.0 degree per fifteen-minute interval has been found to be unwise because of later exhaustion and restlessness which necessitates interruption of the procedure. The maximum temperature necessary to obtain with the diathermy apparatus in the type of treatment under discussion is, we believe, in the range of

103 to 104 degrees, and usually can be reached in one and one-half to one and three-fourths hours. If desired, the rise can be continued by allowing the curve to coast up of its own momentum, aided by the external heat of the cabinet. We have found 104 degrees to be sufficiently high to obtain satisfactory clinical results. We plan to hold a temperature above 103.5 degrees at least two to four hours. Then the electrodes may be removed through the head-end of the cabinet, without exposing the patient, at any time after the diathermy is discontinued. The cabinet is usually removed when the temperature has descended to 100 degrees, and at that time iced fruit juices are given slowly. As before mentioned, the art of administering the diathermic current and cabinet heat in consonance with the patient's individual reaction is a great factor in the success of the treatment, and can be gained only by experience.

RESULTS

Our series of cases of gonorrheal arthritis is relatively small, consisting of only nine arthritics, plus one case of prostatitis and one case of acute epididymitis. Of the nine cases of arthritis, eight were acute and one chronic. Of the eight acute cases, seven, or 87 per cent, were completely relieved of all arthritic symptoms in from one to five weekly treatments with a temperature duration of from one-half to four hours over 103.5 degrees. The one chronic case showed diminution of swelling and pain; but as the x-rays showed joint destruction, complete restoration was impossible. (See Table 1.)

REPORT OF CASES

Case 1.—F. K., male, aet. nineteen, had had an acute gonorrheal urethritis for three weeks. Three days before entrance to hospital, developed an acute g. c. arthritis in right wrist and left elbow, with markedly increased heat, swelling, pain, and tenderness. The first electropyrexia treatment, with the temperature over 103.5 degrees for only one-half hour, gave partial relief of symptoms. The second treatment, with an artificial fever for four hours above 103.5 degrees, gave a complete recovery of both the arthritis and urethritis. Prostatic and vesicular smears remained negative over the period of four months through which he was followed.

Table 1.—*On Results of Treatment*

Case	Sex	Age	Acute Arthritis	Chronic Arthritis	Acute Urethritis	Acute Cervicitis	Acute Epididymitis	Acute Prostatitis	Number of Treatments	Number of Hours Above 103.5°	Relief of Arthritis	Relief of Other Symptoms	Negative Smears
F. K.	M.	19	×	...	×	...	...	...	2	½—4	×	×	×
W. M.	M.	42	×	...	×	...	...	...	3	2—2½—1	×	×	×
*F. J.	M.	55	×	..	×	...	...	...	3	3—101° 3—101° 3—101°	0	0	0
A. L.	F.	19	×	...	...	×	...	...	5	1—2—1½ 2½—2	×	×	×
W. D.	M.	47	×	...	...	...	...	...	1	3	×	..	..
T. P.	M.	46	×	...	×	...	...	...	1	2½	×	0	0
*H. W.	M.	42	×	...	×	...	...	...	2	4—100° 2—101°	×	×	×
C. R.	M.	25	×	...	×	...	×	×	1	3	×	×	×
E. B.	M.	26	...	×	...	...	...	×	2	3—2½	0	×	?
E. D.	M.	25	...	...	×	...	×	...	1	5	..	×	×
Totals			8	...	...	...	...	...	..		7	..	..

Percentages of cures of acute arthritis, 87 per cent.

* Treatment unsatisfactory because of cardiac distress.

Case 2.—W. M., male, aet. forty-two, had had an acute urethritis for fourteen days. Ten days after onset of urethritis, developed massive swelling, with heat and excruciating pain and tenderness in a previously sprained right ankle. The first treatment with hyperthermia of two hours over 103.5 degrees gave considerable alleviation of pain, so much so that he insisted upon another treatment four days later. This time he was held over 103.4 degrees for two and one-half hours. A third treatment of one hour, over 103.5 degrees, gave a practically complete recovery, which was made absolute by a short course of baking, massage, and exercises. Patient was watched for two months and smears remained negative.

Case 3.—A. L., female, aet. nineteen, had had a vaginal discharge for two months. A sprained right ankle was followed by a gonorrheal arthritis, presenting a hot, acutely tender, red and greatly swollen joint. Pain was almost uncontrollable—a true phlegmonous arthritis. A large subcutaneous abscess was opened and drained, but otherwise the ankle was treated conservatively for two weeks. She then was given electropyrexia treatments at weekly intervals for five weeks. The temperature was sustained above 103.5 degrees for from one and a half to two hours on each occasion. The acute symptoms were partially relieved by each treatment. There was some residual stiffness after the last hyperthermia, but this was completely removed by physical therapy, so that there was a complete recovery. Smears were negative during the following month.

Case 4.—C. R., male, aet. twenty-five. This patient had had an acute urethritis for five weeks, and an epididymitis for four weeks. He had received irrigations, with no relief. Three days before hospital entrance he developed an acute prostatitis and arthritis in his left elbow. A single electropyrexia treatment, with fever above 103.5 degrees for three hours, was given. The swelling, pain and tenderness immediately left the elbow, the epididymus and prostate. The discharge ceased, the smears became negative and remained so during two months of observation. There was a complete recovery.

The above résumés present, in a graphic manner, the rather spectacular results obtained in the treatment of gonorrheal arthritis by artificial fever.

SUMMARY

1. Gonorrheal arthritis is systemic manifestation of this specific infection in from 1 to 3 per cent of cases.

2. The organism is thermolabile, and fevers of 103.5 degrees or over are deleterious to gonococcus.

3. Electropyrexia is a convenient means of producing artificial fever.

4. Seven out of eight cases of gonorrheal arthritis were completely relieved by electropyrexia.

1421 State Street.

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DISCUSSION

A. Elmer Belt, M. D. (523 West Sixth Street, Los Angeles).—Credit is deservedly due to Dr. Rodney Atsatt and his technical assistant, Luella E. Patterson, for making available to private patients in California this hazardous but effective method of treatment. The delightful reserve of these authors keeps submerged the perils encountered in the method. Only occasionally do telltale phrases creep in, as "It is absolutely essential that the technician appear calm and self-assured." In these days of extortionate medico-legal judgments for minor burns and injuries, this contribution is especially remarkable.

The author's personal contributions to the method are both exceedingly helpful in increasing the factors of safety. They are his effective method of narcosis, and his idea of transferring the patient to his hot-air cabinet, once the desirable heat level has been established.

Evidence is accumulating to show that strains of gonococci vary greatly in their susceptibility to heat. Dr. Stafford Warren of Rochester, New York, determines this susceptibility *in vitro* for the organisms from each patient before subjecting the patient to fever treatment. He then uses this data as a basis for determining the desirable length of exposure of the patient to heat. Confirmation of the possibility of a correlation between heat susceptibility, *in vitro,* and *in vivo,* is greatly needed.

We have here a thrilling modern picture in which a combination of medical skill and electrical engineering knowledge is brought into combat with desperate disease. We may compare it with the ancient picture of Paracelsus standing by his patient, chronometer in hand, as his heroic dose does its work; on his lips his familiar phrase, "Kill or cure in five minutes."

J. S. Hibben, M. D. (506 First Trust Building, Pasadena).—Doctor Atsatt and Miss Patterson are to be commended for their orderly and systematic presentation of facts, as set forth in their paper. It is very important in physical therapy that an essayist be explicit enough so that the work can be repeated by others under the same conditions in which the former investigation was carried out. This Doctor Atsatt and his associate have done.

The authors' treatment, as outlined, is an electropyrexia treatment both by inductive and conductive methods. The objection to the use of conductive radiant or sometimes called sensible heat, such as actual heat being applied to the patient as in a cabinet, electric blanket or hot water baths, etc., is that flow of heat within the body is inverted or, in other words, that the heat gradient is reversed. The normal generation of heat is within the body and the heat flows outward. In these methods the heat is generated outside and is forced into the body with a high surface gradient. Doctor Atsatt uses a combination of the diathermy and a cabinet, the gradient produced by the diathermy is essentially positive (in the same direction as in a normal body), while the cabinet produces a negative gradient (contranormalcy), the net result is lowering of the total gradient, especially at the surface of the body. Evidence seems to indicate that we may secure a more efficient and rapid elevation of temperature if large quantities of heat are supplied with low gradient, which Doctor Atsatt has done by his method.

I certainly concur with the essayists that an electropyrometer or thermometer for indicating the rectal temperature is an absolute essential. Regarding the use of preliminary sedatives, I have not found it necessary to use these at the beginning of treatment, but employ them after the first forty-five minutes; my preference being one-quarter of a grain of morphin hypodermically. It has been my experience that scopolamin is too uncertain in its action and that many patients have an idiosyncrasy to it.

The authors make no mention in their paper of the use of any replacement chlorid therapy, which is often induced by excessive perspiration in which, in my opinion, is one of the causes of restlessness, aching and pains in the limbs during treatment. I, therefore,

during treatment give the patient by mouth 500 cubic centimeters or more of cold, normal saline solution.

My series of cases of gonorrheal arthritis treated by hyperpyrexia have been small, but from observations I concur with Doctor Atsatt that this is a very valuable treatment for this type of case, and think that when our technique and treatments are improved upon we can expect better results.

✲

Clark M. Johnson, M.D. (384 Post Street, San Francisco).—The subject of gonorrhea and its complications is unpleasant to the laity and profession as a whole. As a consequence, this universal disease is variously and usually poorly treated. Doctor Atsatt, though working with a small series of cases, has contributed something worth while in the treatment of the most disabling and stubborn complication of gonorrhea. The majority of these patients whom I have observed have been in city or county institutions, where they remain as invalids for from three weeks to three months, and are then frequently discharged before they are well. This, in spite of an energetic attack upon the local focus, immobilization of involved joints, local heat and vaccine therapy of various sorts. Intravenous mercurochrome has also fallen far short of its anticipated results. Vigorous, or too energetic treatment of any type of the acute case of gonorrhea with fever, should be done most guardedly and not by the uninitiated. I have had reported to me recently one death from hyperpyrexia, induced by typhoid vaccine in a young man, and have personally observed the induction of a gonorrheal bacteremia caused by the same means, proved by blood culture, which fortunately terminated favorably. Electropyrexia requires time, patience, attention to minute details and more than a casual examination of the patient, such as is usually denied these tragic sufferers from gonorrhea. This should be no deterrent in our attempt to shorten the invalidism and prevent permanent deformity in these cases. This frequently and rightly requires the combined judgment of orthopedist, internist, and urologist. No one attack upon the problem is as yet safe or sufficient. Electropyrexia, because it is controllable, should be more generally available for the treatment of gonorrheal arthritis.

✲

Norman Epstein, M.D. (450 Sutter Street, San Francisco).—Among the conditions treated by means of artificially produced fever none have responded better than gonorrheal arthritis. This has been in contrast to the somewhat disappointing results obtained by this form of therapy in the other types of arthritis.

Several methods of producing hyperpyrexia by mechanical means have been introduced during the past five years. Diathermy, radiothermy, and the use of radiant heat obtained from an external source, have been successfully employed. In general the therapeutic effects have been similar, regardless of the way in which the fever has been produced. It is generally agreed that the essential factor in this treatment is the elevation of body temperature.

In our experience, hyperpyrexia is most easily and simply produced by means of radiant heat from a common electric body bake, placed over the patient's bed as described by the essayists, and the prevention of heat loss from the body by wrapping him carefully in woolen blankets.

During the course of our work as to the effects of artificial fever upon the various phases of syphilis, a number of patients with gonorrheal arthritis were treated. These patients received pyrotherapy every five days. The body temperature was maintained between 39 degrees centigrade (102.2 degrees Fahrenheit) and 40.5 degrees centigrade (104.9 degrees Fahrenheit) for six hours. Three to eight treatments were given. The clinical results obtained were very similar to those reported by the authors. Rapid relief of pain with increased mobility of the affected joints, and prompt recovery occurred in eight of the ten cases observed.

The essayists have reported a method of treatment which is a definite contribution to the therapy of gonorrheal arthritis.

✲

Doctor Atsatt (Closing).—In closing, I wish to thank the discussers for their presentations. In several discussions the note has been struck that the diathermy method is not without danger. This is perfectly true. We hope at a later time to present the details of an apparatus which will cut this danger to a minimum, and still produce an absolutely controllable hyperpyrexia.

COCCIDIOIDES GRANULOMA*

WITH A REPORT OF EIGHTEEN CASES OF COCCIDIOIDES GRANULOMA WITH TWO APPARENT CURES

By Eliot D. Sorsky, M. D.
AND
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Discussion *by K. F. Meyer, Ph.D., San Francisco; Emmet Rixford, M.D., San Francisco; William J. Kerr, M. D., San Francisco.*

SINCE its recognition by Posadas and Wernike[1] in 1892, coccidioides granuloma has become a disease of more than scientific interest, particularly here in California.[2,3] Apart from increased alertness of physicians in recognizing this fungoid infection, especially in pulmonary, skin, and bone lesions, there appears to be an actual increase in the number of cases. At the General Hospital of Fresno County, a diagnosis of coccidioides granuloma has been made in eighteen patients during the past eight years; of these, nine, or 50 per cent, were observed within the past year.

The eighteen cases herein presented are published with a twofold purpose. Primarily, we wish to emphasize certain criteria upon which an earlier correct diagnosis can be made, or at least entertained; and secondarily, we wish to present our experience with some of the forms of therapy now in vogue. With these objectives in mind, we shall consider the subject under two headings.

DIAGNOSIS

In coccidioides granuloma, as in most other diseases, a correct diagnosis may be made in a large percentage of cases only through the routine of taking a detailed history, a careful physical examination, and the assistance of the laboratory. Our subject will be discussed, accordingly, under these subdivisions:

History

Although there is a considerable pleomorphism in the manifestations of coccidioides,[4] a review of the complaints presented reveals certain findings common to most patients. In a large share, the initial symptoms were loss of weight and strength, malaise, anorexia, weakness, general debility, constipation, and inability to regain their vitality following what was apparently an influenza. It is this train of symptoms that usually brings the patient to the physician. In addition to these gen-

*From the General Hospital of Fresno County.

TABLE 1.—*Differential Diagnosis of Tuberculosis and Coccidioides of the Lung*

Differential Point	Coccidioides	Tuberculosis
History of exposure	—	+
Occupation	Outdoor—usually farmer	±
Geographic location	Most frequent in California	Universal
Night sweats	Uncommon	Common
Sputum	Coccidioides immitis found Less sputum	T. B. bacillus found More sputum
Cough	Less severe	More severe
Hemoptysis	Uncommon	Common
Manteau	±	+
Skin lesions	More frequent	Less frequent
X-rays of chest	Fairly characteristic	Characteristic
Fever	Less diurnal variation	Diurnal variation more marked
Guinea pig inoculation	Definite postmortem findings	Definite postmortem findings

eralized complaints, the patient, as a rule, presents single or multiple cutaneous lesions. These may appear in a great variety of forms, and will be discussed more fully under the heading of objective findings. In the cases with pulmonic involvement, there may or may not be subjective symptoms directly referable to the respiratory tract. Cough and sputum are frequent. On the basis of these symptoms, one is frequently led to consider the condition due to a tuberculous infection. The differential diagnosis is often one of extreme difficulty. In our series of ten pulmonic cases, we have found the points listed in Table 1 of extreme importance in making this differentiation. It is not unusual, in comparatively far advanced pulmonary cases of coccidioides, to find all the symptoms referable to cutaneous lesions rather than to the respiratory tract. The systemic reaction to pulmonary lesions in coccidioides granuloma is apparently much less than an equal degree of pathology caused by the tubercle bacillus.

Most writers have noted a particular predisposition of the Mexican race toward coccidioides. In our cases it will be noted (Table 2) that ten, or 55 per cent, are of Mexican descent. It is difficult to determine whether this is actually a matter of racial susceptibility or merely a reflection of the occupational and environmental status of that race. In reviewing the occupations of our patients, we find the disease most prevalent among the laborers in the fruit orchards. The fact that the San Joaquin Valley, as a center of the fruit-growing industry, is also the source of a majority of the reported cases of coccidioides may be of some significance.

As to distribution between the sexes, coccidioides is most frequently found in the male. Of our eighteen cases, fourteen, or 78 per cent, were male patients. This is in all probability due to occupational hazards rather than inherent sex predisposition. The age incidence of our cases presents no particular decades as periods of greater susceptibility to invasion by the coccidioides organism.

A history of trauma [5] was obtained in only two of our cases. The first patient was a young Mexican female, age twenty-two years, who accidentally scratched the medial surface of her right thigh with her fingernail while dressing. A slight swelling appeared at the site of the bruise, soon broke down and left a draining sinus. Following this over a period of six months, multiple lesions appeared, and x-ray plates subsequently showed pulmonary involvement. This history lends evidence for those who feel that in a portion of coccidioides cases the portal of entry is through the abraided skin rather than through inhalation. Our only other case giving a history of trauma was a young negress, age twenty-one years, who in 1920 received a blow from a stone in the mid-portion of the left forearm. The resultant pain and swelling soon disappeared, but tended to recur during the ensuing years. In 1924 she was operated upon and the swelling incised. No record of the findings at that time are obtainable. She was seen again in this hospital on January 31, 1927. At this time pus aspirated from the lesion revealed the coccidioides organism on smear and culture.

Physical Examination

The close similarity of tuberculous and coccidioides cases is borne out also in the physical examination. In the far and moderately far-advanced fungoid cases we find a cachetic, emaciated, and anemic patient. In the majority of cases there is some cutaneous involvement. The appearance of the lesions, however, is not usually characteristic, due to the multiform cutaneous manifestations of the disease. The lesions, when first seen, are most frequently considered of tuberculous origin. A detailed description of the cutaneous lesions will not be attempted here, since adequate literature is already available on that phase of the subject. Possibly the most characteristic skin lesions are multiple subcutaneous abscesses, varying in size from a small pea to the size of a large grapefruit. The overlying skin may be entirely normal or may show the presence of underlying infection by a markedly reddened appearance. Pain is associated with these cutaneous lesions in about one-half the cases. No portion of the body surface including the scalp, face, trunk, or extremities, is immune to cutaneous abscesses. Another type of skin involvement commonly described in coccidioides, but seen in only one of our cases, is the open, chronic ulcerating lesion. This patient, Mrs. R. B., age thirty-eight years, presented herself for the first time on December 8, 1931. She showed an extensive granulating lesion of the right side of the face and neck of nine months' duration. The ulcerating surface extended from the outer canthus of the eye almost to the midline at the back of the neck, and from just above the clavicle below well up into the scalp. The ear was also involved. It is this type of ulcerating lesion that advances slowly, and eventually terminates

TABLE 2.—*Notes on Eighteen Patients*

	Name	Age	Sex	Occupation	Nationality	Site of Involvement	Duration of Case	Presenting Complaints	Termination	Method of Diagnosis
1	J. S.	20 yrs.	Male	Laborer on fruit ranches	Mexican	Abscesses of neck and chest.	14 months	Abscesses right side of neck and left lower chest.	Died	Smear of pus. Confirmed by autopsy.
2	R. B.	38 yrs.	Female	Housewife	American	Pulmonary coccidioides. Granulating ulcer of face and neck.	Unknown	Large granulating lesion on side of face.	Unknown	Smear of pus.
3	G. L.	38 yrs.	Male	Laborer	American negro	Abscesses of face, neck, back and extremities; pulmonary.	3 months	Multiple abscesses. Pain in back and weakness.	Died	Smear of pus. Confirmed by autopsy.
4	S. M.	60 yrs.	Male	Laborer	Mexican	Two abscesses of chest wall.	Unknown	Abscesses on right shoulder, over scapula, and right lower chest.	Unknown	Smear of pus. Guinea pig inoculation.
5	J. C.	35 yrs.	Female	Worker in vineyards	Mexican	Abscesses of ribs, spine, and forehead; also lungs and peritoneum.	9 months	Multiple boils, loss of weight, fever, weakness, and constipation.	Died	Guinea pig inoculation. Confirmed by autopsy.
6	A. M.	43 yrs.	Male	Laborer in vineyards	Italian	Multiple cutaneous abscesses; pulmonary involvement.	14 months	Multiple abscesses, weakness, loss of weight, cough, and anorexia.	Died	Guinea pig inoculation.
7	Q. V.	36 yrs.	Male	Laborer on fruit ranch	Mexican	Multiple cutaneous abscesses; pulmonary involvement.	18 months	Multiple cutaneous abscesses, cough and pain in chest, and loss of weight.	Died	Smear of pus. Confirmed by autopsy.
8	S. L.	26 yrs.	Male	Laborer on fruit ranch	Mexican	Abscesses of face, neck, and forehead; probably pulmonary.	6 months	Multiple cutaneous abscesses, cough, fever, and loss of weight.	Died	Smear of pus.
9	N. T.	40 yrs.	Male	Laborer	Mexican	Multiple abscesses of chest wall.	Unknown	Multiple cutaneous abscesses, headaches, and stiff neck.	Unknown	Smear and culture of pus.
10	E. A.	8 yrs.	Male	School child	Mexican	Draining sinus medial upper aspect of left thigh.	7 months	Chronic draining sinus, left thigh.	Apparently cured	Smear of pus.
11	A. F.	55 yrs.	Male	Laborer	Chinese	Multiple abscesses of hands, feet, chest, and pelvis; pulmonary involvement, unilateral.	19 months	Multiple painful cutaneous abscesses; cachexia and emaciation, and irritability.	Died	Smear and culture of pus. Confirmed by autopsy.
12	V. S.	38 yrs.	Male	Sheep herder	Spanish	Pulmonary and meningeal involvement.	25 months	Emaciation, loss of weight, chronic cough, and headache.	Died	Culture of spinal fluid.
13	E. T.	21 yrs.	Female	Housework	American negress	Left ulna.	7 years Unknown	Pain and swelling left forearm.	Unknown	Smear of pus.
14	H. G.	43 yrs.	Male	Cook	American	Multiple cutaneous abscesses on chest wall.	6 months	Multiple cutaneous abscesses, malaise, and loss of weight.	Died	Smear and culture of pus. Confirmed by autopsy.
15	E. H.	23 yrs.	Male	Railroad worker	American negro	Lungs and peritoneum.	17 months	Weakness, hemoptysis, loss of weight, and chronic cough.	Died	Confirmed by autopsy.
16	F. R.	45 yrs.	Male	Laborer-gardener	Mexican	Large subcutaneous abscesses over lower lumbar spine.	11 months	Abscesses over left lower lumbar region, loss of weight, and weakness.	Died	Smear and culture of pus.
17	M. A.	22 yrs.	Female	Housewife	Mexican	Draining sinus, right thigh; and abscesses of neck and right axilla.	8 months	Weakness, right sided headache, multiple cutaneous abscesses, and loss of weight.	Apparently cured	Smear and culture of pus.
18	I. A.	13 yrs.	Male	School child	Mexican	Lesions in lungs, liver, kidneys, spleen, peritoneum, adrenals, lymph nodes and meninges.	1 month	Fever, headache, nausea and vomiting, speech aphasia, and signs of meningeal irritation.	Died	Confirmed by autopsy.

Total: Male, 14; female, 4; Mexicans, 10; negroes, 3; Americans, 2; Spanish, 1; Chinese, 1; Italian, 1.

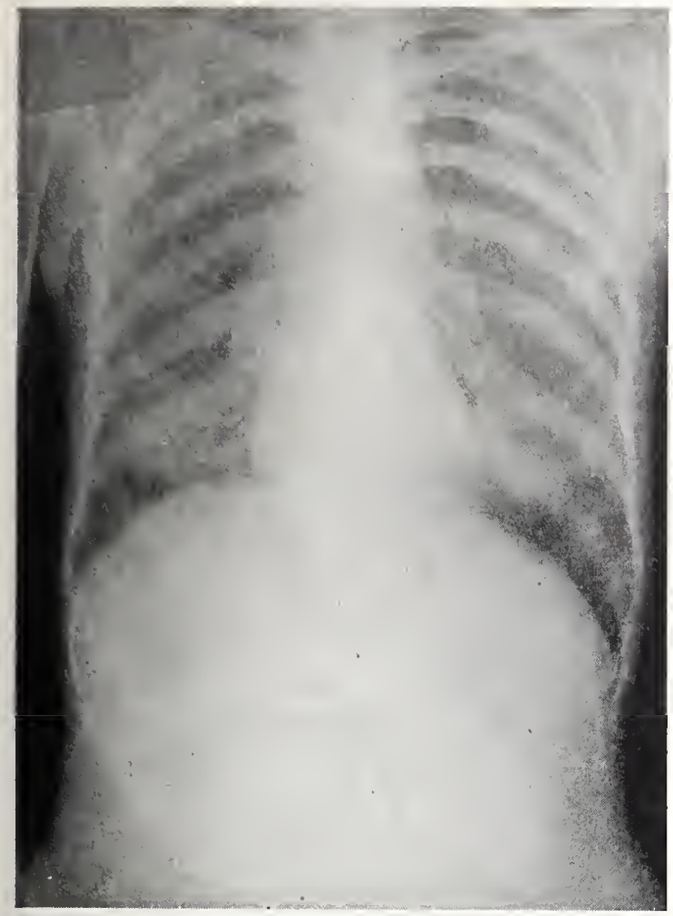


Fig. 1.—Chest plate of Case No. 2

fatally by increasing cachexia or by further systemic involvement.

On general physical examination there are no findings particularly characteristic or indicative of the type of infection with which we are dealing. The extreme cachexia of the far-advanced case of coccidioides granuloma is exactly similar to that in any of the so-called wasting diseases, such as cancer or tuberculosis. A fairly constant finding in our series of cases was marked caries of the teeth and pyorrhea. Physical examination of the chest in those patients with pulmonic involvement gave findings quite similar to those noted in pulmonary tuberculosis. Findings in all but one of our cases were bilateral and rather far advanced. Careful palpation of the chest often will reveal either small subcutaneous abscesses, or actual involvement of the ribs or sternum by the invading organism. Such findings should always make the physician suspicious of some pathological process other than tuberculosis.

Symptoms

In those cases of coccidioides infection having meningeal invasion,[6] the symptoms are those usually found in tuberculous meningitis; the objective findings are also in no way suggestive of the specific type of invasion. It is not uncommon in this type of involvement to discover, by x-ray, defects of the inner table of the skull. This is, of course, an important finding in the differential diagnosis of this type of meningitis from that of the tuberculous type. In both cases of coccidioides meningitis herein reported there was, in addition, a general systemic involvement including extensive bilateral pathology in the lungs. Before entry to the hospital, one case had been considered as a generalized tuberculous infection. It was not until culture of the spinal fluid revealed the presence of coccidioides immitis that the diagnosis was made clear.

Laboratory Findings

The etiologic agent of coccidioidal granuloma has variously been termed coccidioides immitis, oidium coccidioides, and fungus coccidioides. The organism has a double cycle of growth—one in tissues and exudate, the other in natural or artificial culture media. In animal tissues the adult form is a spherule, 5 to 60 microns[7] in diameter, with a refractile double-contoured capsule and usually a faintly granular cytoplasm. Reproduction in animal tissue is by means of endospores, which rupture through the capsule and develop into adult organisms. Mycelia are found only in culture media, natural or artificial. Endospores develop in the terminal segments of the hyphae. In a liquid culture media the mycelia network sinks to the bottom of the tube.

The recognition of the organism in pus or sputum presents no great difficulty.[8] It may be identified in an unstained preparation with the high dry objective and the light restricted by the diaphragm, or in preparations stained by the Gram stain in which the organisms are Gram-negative.

The organism is an aerobe, and grows readily on many culture media. Sabourand's media is perhaps the optimum one. On this and other solid media in plates it is seen as a white or grayish white cotton-like growth which spreads, from centers, throughout the plate. In liquid media, as broth, it is found as a stringy mass in the bottom of the tube.

Animal inoculations are very satisfactory for diagnostic confirmation. Suspected material is inoculated intraperitoneally. If a male guinea-pig is used, an orchitis develops early; and in ten to fourteen days definite symptoms and pathologic changes develop with the disease running a course of four to six weeks. Lesions similar to those of tuberculosis are found in the spleen, liver, lymph, nodes, and lungs. A thick, tenacious pus is present in which the double-contoured capsules are found.

The lesions in animal tissues are similar to that of other infectious granulomata. Ophüls[9] describes them as "submiliary, miliary or larger nodules which resemble tubercles very closely. These nodules may caseate. Later the caseous material may liquefy, and cavities containing pus-like material may be produced in this way; or in other cases there may be suppuration from the beginning, sometimes of a rather acute type, but usually of a more chronic character, leading to the formation of miliary, or larger, sometimes very large chronic abscesses or ulcers."

In whatever tissue the lesions are found the microscopic picture is very similar to that of tuberculosis. There is tubercle formation with round-celled infiltration, caseation, and giant cells. Apart from the organisms, if there is any difference in the microscopic appearance of the lesions it is in the greater number of giant cells in the

TABLE 3.—*Special Laboratory Tests*

Case No.	Spinal Fluid	Gastric Expression	Blood Chemistry
14	Yellow fluid Smear—Few red blood cells Culture—no growth	*Free HCL* — *Total Acid* 1-..-00 — 60 2-..-00 — 15 3-..-00 — 10 4-5-00 — 03 Smear—No evidence of coccidioides immitis	Glucose—87.8 milligrams per 100 cubic centimeters blood N. P. N.—31.5 milligrams per 100 cubic centimeters blood
16	Clear fluid Cell count normal Culture—no growth	1-2-06 — 06 3-4-10 — 10 5-..-02 — 06 6-..-00 — 02 Smear—No evidence of coccidioides immitis	Glucose—80 milligrams per 100 cubic centimeters blood N. P. N.—24 milligrams per 100 cubic centimeters blood
17	Clear fluid Cell count—2 Noguchi + Smear and culture negative	1-..-00 — 10 2-3-00 — 10 4-5-00 — 00 6-..-00 — 05 Smear—No evidence of coccidioides immitis	Glucose—83.3 milligrams per 100 cubic centimeters blood N. P. N.—30 milligrams per 100 cubic centimeters blood
9	Slightly turbid fluid Cell count—4 Smear—occasional red blood cells Wassermann—negative		
18	Turbid fluid—increasing pressure Cell count—240 50% polymorphonuclears 32% small lymphocytes 18% large round cells Culture—positive in forty-eight hours Gold curve—5-5-5-5-5-5-3-3-2-1		

lesions of coccidioidal granuloma. From the standpoint of the laboratory diagnosis the organisms may be found, as previously stated, in pus and sputum, and also in the cerebrospinal fluid and, rarely, in the blood.[10] Other than the identification of the organism, there is nothing especially diagnostic in laboratory tests. The blood count usually shows a moderate leukocytosis, but there may be a normal leukocyte count or even, occasionally, a leukopenia. The leukocytosis probably depends on a secondary infection. In cases where there is a meningeal involvement, the cerebrospinal fluid findings are similar to those of tuberculous meningitis, except in the colloidal gold curve. There is a pleocytosis with an average count of 200 to 500 cells, predominatingly lymphocytic, and a colloidal gold curve in Zone 1. As stated above, the organisms may be found directly in the spinal fluid, by culture or animal inoculation. (See Table 3.)

If the possibility of coccidioides granuloma is considered in radiographic interpretation, the x-ray[11,12] is of assistance in diagnosis. However, there is nothing pathognomonic in the roentgenological picture of the lesions of this disease. In our series of cases the most common radiographic picture shown by the lung lesions may be described by the term "snowstorm." These are discreet, small, fairly well circumscribed opacities, usually evenly distributed throughout the lung fields in the more advanced cases. The picture closely resembles that of a miliary tuberculosis. Cavitation or consolidated lesions are not characteristic of this disease. Bone lesions are fairly common, and are seen radiographically either as solitary punched-out areas or as a more widespread osteomyelitis.

TREATMENT

Of the great number of therapeutic measures applied in the treatment of coccidioides granuloma, none have shown more than transitory effects. The number of medications suggested and used from time to time are legion. In our hands no single plan of medication had been consistently efficacious. With certain preparations we have noted transitory improvement in a few of our subjects. In two cases we have what we hope will result in a permanent and complete cure. The same medication, however, when applied to other cases has been entirely without results.

In reviewing the multiform variety of therapeutic measures employed in this series of cases, we find a fairly complete survey of the various medications and procedures recommended by the numerous experimenters in this field. We shall attempt to enumerate these various methods and record our results in each case.

In the general treatment of these patients there are several important factors to be considered. The nourishment of the patient must be maintained. This is, in many cases, an exceedingly difficult problem. The use of high caloric, high vitamin, and high mineral diet is essential. The tendency in these patients toward a progressively more severe secondary anemia is striking, and the usual medical anti-anemic regimen is strongly indicated. Various forms of iron, as ferrum reductum or liquid Blauds, should be employed. In the more severe cases repeated small transfusions are indicated in an effort to stimulate the patient's own hematopoietic system. Elimination must be carefully watched and, when necessary, mild laxatives or cathartics must be employed. The occurrence of decubetant ulcers is frequent, and often



Fig. 2.—First case of coccidioides in California, 1893.

the cause of considerable discomfort on the part of the patient and those associated in his care. The usual preventive precautions, as constant change of position, massage, and use of cushions, all aid in the prevention of bed sores. Bed rest is essential in the acute types of coccidioides. However, in those patients in which the disease assumes a chronic form it is advisable whenever possible to allow the individual to be up and about. This not only acts as a general stimulus and tonic to the vital functions, but aids materially in sustaining the hopeful outlook of the patient. General sedatives and hypnotics must be used in greater or lesser amounts, depending on the extent of involvement and the location of the lesions. In the terminal stages, morphin is frequently necessary for the control of pain.

There is as yet no specific medication which has shown consistently satisfactory results. In several instances we have noted transitory, although definite, improvements following certain drugs. In still other cases we feel that general systemic invasion of the patient by the disease was inhibited with a resultant prolongation of the life span.

The use of one per cent antimony and potassium tartrate intravenously has brought about definite improvement in cases reported by Guy and Jacob in 1927 [5] and by Tomlinson and Bancroft in 1928.[13] In our series this form of medication has been administered in two cases. In one patient 5 cubic centimeters of the solution were injected intravenously for forty injections, extending over a period of two months. No clinical response was noted and the patient died. Our second case also received 1 per cent methyl violet intravenously. Neither of these medications appeared to affect the course of the disease.

Saturated solutions of potassium iodid have long been used in treatment of fungoid infections. This medication has not shown any beneficial effects in coccidioides granuloma, but for want of a more specific drug has been used widely. In this series of cases it was given internally in ten cases, the dosage varying from 10 to 50 minims three times daily. This medication was always used in conjunction with some other form of therapy. No beneficial results were noted, and in the larger doses reactions were obtained in the form of skin eruptions. It was felt that possibly a greater concentration of the iodids [14] internally might inhibit further progression of the disease, and so in conjunction with the saturated potassium iodid by mouth large doses of 10 per cent sodium iodid were given intravenously. Two grams of sodium iodid were given daily, or on alternate days over a period of a month. This therapy was employed in four cases. In only one case could improvement be noted. This patient is free of symptoms at the present time. Sodium iodid has also been given by mouth with no apparent beneficial results.

The therapeutic value of colloidal copper in treatment of coccidioides was first noted by Jacobson [15,16] in 1927, who described its effect on two cases. This form of therapy [17] was tried in only one of our cases. The copper was administered in 5 cubic centimeter doses intramuscularly twice weekly. Following a single intravenous injection there was considerable systemic reaction, and this mode of administration was discontinued. We feel that our experience with colloidal copper is too brief to justify an opinion as to its value in coccidioides. In an effort to further evaluate the efficacy of the heavy metals as therapeutic agents, we administered intramuscular bismuth in the form of "Bismoid." Intramuscular injections of 2 cubic centimeters were given twice weekly for a period of over twelve weeks. In conjunction with the administration of gentian violet the Bismoid apparently gave beneficial results. The patient receiving the above medication was the Mexican female, age twenty-two years, already referred to. She developed a draining sinus following a scratch of the right thigh with her fingernail while dressing. Within three months the patient developed three other draining sinuses, and a large subcutaneous abscess. There was no pulmonary involvement. Large doses of iodids orally and intravenously did not apparently affect the course of the disease. As noted above, the use of colloidal copper also showed no beneficial results. Following this, bismuth was given as stated above. In addition, 2 per cent gentian violet was used locally, and two injections of 15 cubic centimeters of 1 per cent gentian violet were given intravenously. There was noted a slow but gradual improvement. At the present time all cutaneous lesions have disappeared, and the patient is receiving no medication other than 10 minims of a

saturated solution of potassium iodid three times daily.

Because of the apparent beneficial results of intravenous gentian violet in coccidioides noted by several writers,[1] this form of medication was tried in two cases. In the first patient, 12 cubic centimeters of a 1 per cent solution were given intravenously at weekly intervals for five doses. No improvement followed, and the patient died. In a second case the administration of 10 cubic centimeters of a 1 per cent solution of gentian violet intravenously three times weekly, for five weeks, together with gentian violet locally, resulted in definite improvement. The patient, however, left the hospital against consent. In a third case methyl violet was given intravenously for six injections. No improvement was observed.

Local treatment of cutaneous lesions has been as varied as the general therapy. The medications applied include the usual antiseptics, various iodin solutions, and gentian violet. In our hands gentian violet in one-half to three per cent solution has been especially efficacious. Following its application, the amount of pus in the individual lesions decreases markedly, and if the treatment is persisted in, complete local healing is frequently noted. Incision of local lesions for more adequate drainage is in most cases contraindicated. Secondary infection soon follows, and there is much breaking down of tissue. Open drainage should be resorted to only when the overlying skin is about to break down. If adequate treatment is commenced early, this will not usually be the case. Under aseptic precautions a needle should be inserted into the abscess and the pus removed. A large bore needle is usually required because of the tenacious character of the pus. Following aspiration, a somewhat smaller amount of 1 per cent gentian violet should be reinjected. On repeated injections the concentration of gentian violet may be increased to 3 per cent. The rapidity with which the amount of pus decreases, following aspirations, is often quite striking.

The use of 5 per cent potassium iodid, to which iodin crystals have been added to the point of saturation as first recommended by H. A. Ball,[14] was applied in only one of our cases. This patient (Case No. 10) entered the hospital with a draining sinus in the left thigh. His brother had died about nine months previously of a generalized coccidioides (Case No. 18). The solution was applied locally as a wet dressing, and within three and one-half months complete healing resulted. We feel that in this case the organism was of low virulence, and the resultant apparent cure was possibly due more to this fact than to a specific efficacy of the iodin solution. Further trial of this solution, however, would certainly seem indicated.

SUMMARY

Eighteen cases of coccidioides granuloma are presented and discussed under the headings of diagnosis and treatment. The salient points relating to history, physical examination, and laboratory findings are given, with special emphasis toward early diagnosis. The treatment of coccidioides granuloma is considered under the general subdivisions of general therapeutic measures, specific medication, and local treatment. Our results, following the application of the various types of medication now in use, are noted. Local treatment by closed aspiration and the use of gentian violet is emphasized.

CONCLUSIONS

1. Coccidioides granuloma is a more common infection than generally realized.
2. The similarity in the onset and course of both coccidioides granuloma and tuberculosis is noted, and the salient points in the differential diagnosis emphasized.
3. The usual findings in physical examination of these patients is presented.
4. The physical and growth characteristics of coccidioides immitis are noted, and the various laboratory aids which facilitate diagnosis are described.
5. A review of the medications applied in this series of eighteen cases is presented, with the results obtained in the use of each. It is suggested that the results from bismuth, colloidal copper, and gentian violet warrant their further trial.
6. In the local treatment of the abscesses it has been found advisable to use a closed method wherever possible. Gentian violet irrigations, in from one to three per cent, have in some cases given very satisfactory results.

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DISCUSSION

K. F. Meyer, Ph.D. (Hooper Foundation for Medical Research, San Francisco).—The valuable report by Doctors Sorsky and Nixon stresses again the occupational character of coccidioidal granuloma. Whatever may be the definition of "occupational disease," it is unquestionably true that the humble, and yet the most important of all laborers, the tiller of the soil, is exposed to this blastomycotic infection which, by reason of his occupation, constitutes a hazard. The epidemiological studies summarized in 1931 by Beck (State Department of Public Health, Special Bulletin 57, p. 19), suggested the soil and the vegetation as the probable sources of the fungus infection. The peculiar geographic distribution of coccidioidal granulomas, both in man and animals, to the central and southern sections of the State, supports this contention. Since the customary bacteriologic technique failed to demonstrate the organism in a great variety of soil specimens, Stewart and Meyer (*Proceedings of the Society of Experimental Biology and Medicine, 29*:937, 1932), devised a method to concentrate the fungus spores. In the earth collected around the sleeping quarters at a ranch near Delano, Kern County, where four cases of granuloma had been observed among the Filipino working crew, the mold was demonstrated. The guinea-pigs inoculated with the specially preparel soil sediment developed typical generalized infections. Similar studies in other parts of the State appear desirable. In fact, a renewed investigation of the cause of coccidioidal granuloma is imperative, in view of the brilliant researches by Floriano de Almeida in Brazil (As Blastomycosos no Brazil, *Annaes da Faculdade de Medicina de São Paula,* IX, pp. 1-97, 1933, English Summary). According to this investigator, two additional forms of blastomycosis have been recognized: "Pseudococcidioides mazzai," first observed by Mazza and Parodi in a case of laryngeal fungoidal disease, and "Paracoccidioides braziliensis." Based on careful studies, de Almeida showed that the double contoured capsules contain small spores and peculiar peripherally arranged chromatin masses. The colonies form aerial hyphae. His findings have been confirmed by Weidman and others, who have seen these cultures and the lesions produced in the guinea-pigs. Paracoccidioidal granuloma is widely distributed in Brazil—a total of 257 cases (228 males) having been recognized. It has been described as a malignant lymphogranulomatosis, accompanied by extensive involvement of the liver, spleen, and intestines. Since the portal of entry of the mold is doubtless the buccal cavity, lesions on the tongue, tonsils, and pharynx are by no means uncommon. The reasonableness of the theory that the North American coccidioidal granuloma may be caused by a group of molds rather than by a single species should not be ignored. In future, inquiries should also be directed toward an elucidation of the underlying factors of susceptibility and resistance to blastomycosis. The problem of allergy, the character of the cellular elements in the immune reaction, deserves the attention of those who have access to clinical and pathological material.

Emmet Rixford, M. D. (1795 California Street, San Francisco).—It is of great interest to me, of course, to note the amount of work that has been put upon the subject of coccidioidal granuloma in recent years. Doctors Sorsky and Nixon have given in this paper an excellent and very complete discussion of the clinical aspects of this disease. They have also given something of a bibliography, but a much fuller bibliography is published in Special Bulletin No. 57 of the California Department of Public Health, 1931, and since 1931, a number of articles have appeared, and much work has been done on the biology of the organism. For example, it has been known for some years that the organism in spherical form is found occasionally in cattle and sheep; and we know from our early experiments that it will grow in other animals. I personally succeeded in inoculating a dog in 1894, recovered the organism from his lesion six months later, and others have successfully inoculated guinea-pigs and other animals. We long ago suggested and expressed the hope that the organism would be found in nature (soil or decaying organic matter) as a mold.

Perhaps the most important recent finding, however, is that of R. A. Stewart of the Bacteriological Department of the University of California, who succeeded in finding the organism in the door-yard soil of a farm near Bakersfield, from which a number of human cases had come (*Proceedings of the Society of Experimental Biology and Medicine,* May, 1932). In ordinary culture media, and apparently in soil, the organism is a mold.

The name is somewhat unfortunate because it means "resembling coccidia," which are protozoa (animal organisms). In studying our first case (1893), we thought the organisms were protozoa, related to coccidia. However, we sent the material to Doctor Welch of Johns Hopkins University, where much work was done on it by the late Dr. T. C. Gilchrist (Johns Hopkins Hospital Reports, 1896), who in turn sent the material to Doctor Stiles of the Agricultural Department at Washington, an authority on protozoa, for identification; and it is an interesting commentary on human frailty in its anxiety to record new things without adequate study, that Doctor Stiles admitted that he did not know what the organism was, but did not hesitate to name it coccidioides. There were two forms—C. immitis (savage) and the organism from the second case, C. pyogenes, the latter organism being different from the first in its larger size, its smaller number, and relatively larger spores, arranged about a hyaline nucleus.

I have since learned from Dr. Roscoe Pound, professor of law in Harvard University and a world authority on international law, who has, for at least one of his hobbies, a very intimate knowledge of these primitive fungi, that the second form is not a different species, but is simply one of the polymorphous stages of the same organism.

As far as I have been able to learn, only one case has since been reported of the organism which was present in our second case (Thorne's)—this by Dr. Erwin P. Zeisler of Chicago. Doctor Zeisler's patient died within six months of the time of discovery, in spite of a course of treatment with colloidal copper and tartar emetic, no visceral involvement being demonstrated, although no autopsy was done. I mention this matter because it may be that there are two groups of cases, one the more common, *i. e.,* infected with the smaller organism, in which the prognosis is not nearly so unfavorable as we originally thought; for a number of cases have been cured, some following the administration of various drugs, but probably more important than drugs, under supportive treatment and rest, as in tuberculosis. Moreover, in a number of cases there have been demonstrated cured lesions in the lungs containing dead capsules of the organism, showing that without treatment the natural resistance of the body has in some instances controlled the disease. It may be that in cases in which the organism is of the second form, the disease is more virulent. Two cases are of course too few to warrant any such generalization, but I would urge that careful study on future cases be given to this aspect of the matter. In Brazil there have been found still other forms of a similar organism, producing similar lesions. Their biological relations with the organism which is in California have not as yet been

worked out. One of them, published by Almeida, exhibited a spherical organism with spores budding off from the outside of the capsule, and yet distinct from the conventional forms of blastomyces.

Fig. 2 is a photograph of the original California patient, 1893.

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William J. Kerr, M. D. (University of California Medical School, San Francisco).—This excellent paper emphasizes the frequency of the disease in the San Joaquin Valley, and suggests the probable source of the infection in the soil. In our State, where we are coccidioides-minded, the disease is frequently and justly suspected. However, the diagnosis is still missed when cutaneous or pulmonary symptoms exist alone, or where the meninges are affected. In some cases the double contoured sporulating bodies in the spinal fluid may be mistaken for red or white blood cells when the examiner does not take into account the large size of the objects. We have had some difficulty in demonstrating the organisms in the discharges when tissue from the wall of the sinus showed them in stained sections. The use of tartar emetic should be advised during the early stage of pulmonary involvement. We have tried vaccines, but without any striking success. Drainage of the abscesses may give temporary relief of symptoms, but at present the outcome is quite hopeless when there is dissemination of the infection.

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Doctor Sorsky (Closing). — The authors desire to express their appreciation to Doctors Rixford, Meyer, and Kerr for the very interesting discussion they have added to this paper.

HYPERTENSION ASSOCIATED WITH UVEITIS*

By Morie Frederick Weymann,† M. D.
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Discussion *by William A. Boyce, M.D., Los Angeles; C. Allen Dickey, M.D., San Francisco; Helen E. Preston, M.D., Los Angeles.*

THIS rather informal discussion will deal mainly with a summation of personal experience in the treatment of the topic under discussion, rather than give an exhaustive survey of what has already been written. The experience and criticism of those who have used similar or other methods of treatment are to be courted for the purpose of sifting out the best measures possible in the care of this condition.

THE TERM "CHRONIC UVEITIS"

The term "chronic uveitis" is used here in the sense of a mild chronic inflammation of the anterior uveal tissues—that is, the iris and ciliary body. In early stages the subjective symptoms may be so slight as to be scarcely noticeable. There is little conjunctival or ciliary injection; there is discomfort rather than pain, and the first symptoms may be only a slight blurring of vision. The etiologic factors underlying the type of uveitis which may be accompanied by hypertension come, for the most part, under the heading of tuberculosis, syphilis, and the focal infections.

It is not uncommon to find that an eye affected with chronic uveitis and secondary hypertension carries the diagnosis of chronic simple glaucoma. This error occurs because the quietness of the inflammation gives a lack of those signs commonly associated with iritis. The one certain method of making a proper diagnosis in these cases is the use of the biomicroscope. It is wise to examine the posterior surface of the cornea and the contents of the aqueous with this instrument in all cases of increased intra-ocular tension, and particularly in younger individuals.

Where a chronic uveitis exists in its very early stages, one finds an increased aqueous flare, a few cells, which are lymphocytes, slowly moving in the convection current of the aqueous, and often a slight edema of the endothelium of the cornea. These lymphocytes appear as white shining points in the beam of the slit-lamp, and should not be confused with the golden-brown pigment cells which are often a normal senile finding, or which appear in the later healing stages of uveitis. As the process progresses, these inflammatory cells become more numerous and begin to settle out as precipitates on the posterior surface of the cornea in the familiar lower triangular segment. These early precipitates have a white, somewhat fatty appearance, but later become flecked with pigment as the pigment cells migrate into the aqueous and also settle out. As healing takes place, the whitish portion of the precipitates absorb during the same period that the lymphocytes disappear from the aqueous. At this stage numerous pigment cells are still present in the aqueous and may not vanish for many months.

WHEN HYPERTENSION APPEARS IN CHRONIC UVEITIS

It is usually during the early stage of a chronic uveitis that one encounters hypertension. The pupil is somewhat wider than normal, and not spastic as in acute or subacute iritis. In the lighter cases the pupil is active to light and there is not much tendency toward posterior synechia formation; although where the infiltration becomes more severe and cells in the aqueous more numerous, posterior synechia may tend to form.

With the diagnosis of hypertension and chronic uveitis established by means of the biomicroscope and tonometer, it becomes necessary to determine the etiologic factor of the uveitis. In younger individuals tuberculosis should always be first considered. After a patient has had a general physical examination to make certain there are no active pulmonary foci, and for the purpose of locating any other foci of infection, diagnostic tuberculin tests are made with Koch's old tuberculin. From the physical findings, the Wassermann test and tuberculin test was gained an idea as to the underlying etiologic factor in about 80 per cent of cases. In the others empirical measures must be resorted to as described later.

LOCAL TREATMENT

The local treatment must be directed at control of the hypertension without, if possible, increasing the severity of the uveitis. If the uveitis is

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sufficiently severe to provoke the formation of posterior synechia, it is necessary to dilate the pupil to prevent this development. Glaucosan and the stronger solutions of adrenalin are no longer used by me because of their severe reaction, and because the following procedures have been found satisfactory. A few drops of adrenalin placed on a piece of cotton and tucked into the upper fornix, after anesthetization with holocain or butyn, will produce a dilatation of the pupil and a diminution in tension which will last from several hours to one day. This is the method described by Gradle. The dilatation thus produced is sufficient to break posterior synechia. As an alternative method the placing of an ophthalmic disk of "Epinin," a Burroughs and Wellcome synthetic suprarenalin, in the conjunctival sac will be found efficacious in dilating the pupil and reducing the tension. These tabloids contain seven and one-half milligrams of the active drug. It has not been advisable to keep the pupil permanently dilated with homatropin or atropin, because of the great tendency in these eyes toward the formation in the angle of anterior synechia when the pupil is widely dilated. When this occurs the eye is usually lost through a gradual increase in tension which responds to no treatment. As the tension subsides, a 2 per cent solution of euphthalmin, used three times daily, will control a tendency toward synechia formation without dilating the pupil sufficiently wide to allow anterior synechia formation to take place.

If the tension is not lessened by the adrenalin packs or epinin disks, one should not hesitate to use repeated paracentesis of the anterior chamber for this purpose. In addition to mechanically lowering the tension, paracentesis favors healing by permitting fresh proteolytic substances to enter the anterior chamber from the blood stream to hasten resolution of the cells and precipitates present there. Early iridectomy is indicated even in the face of an active uveitis, if both paracentesis and the adrenalin do not control the hypertension and produce a favorable turn in the progress of the disease. Many eyes are undoubtedly lost because iridectomy is postponed too long. Certain of the French writers have suggested trephining as a more satisfactory and more permanent method of lowering the tension, but I have found iridectomy adequate in my cases.

The application of dry heat in ten-minute periods, from three to six times a day, has been of marked benefit. This can easily be done by having the patient hold a 40-watt light globe attached to an extension cord close to the affected eye, which is protected from the light by a piece of flannel. The altherm eye-pad which has recently been described, and which furnishes heat by the change of its contents from a fluid to a crystalline state, should also serve this purpose. It is obtained from Meyrowitz in New York. Where other measures fail, or as an adjuvant, a 20 per cent erythema dose of x-ray, particularly in the tuberculous type of uveitis, may have a beneficial effect upon the tension and the uveitis. It should only be repeated at from three- to six-week intervals.

GENERAL TREATMENT

So far as getting a permanent cure of the uveitis which is causing the hypertension is concerned, the general measures are of even greater importance than the local ones. The general hygiene of the patient should be carefully regulated. Sufficient food should be taken so as not to permit a loss in weight. If necessary, a glass of half milk and half cream should be added to the diet between meals. Any tendency toward constipation should be eliminated. The importance of a full night's rest should be emphasized, and a two-hour rest period in the reclining position every afternoon is of advantage. Where tuberculosis is the cause of the uveitis, tuberculin therapy has proved of benefit. The empirical use of ten grains of sodium salicylate three times daily after meals is worth while, for in many cases it seems to help. Naturally foci of infection should be eliminated, but if the hypertension is being controlled by other measures it is better not to disturb active foci of infection until the eye is quiet. Foreign proteins which produce a violent reaction have been found detrimental in many cases, but nonirritating stimulants to leukocytosis such as omnadin (Metz) have been used with benefit.

IN CONCLUSION

From the above it may be seen that to treat the hypertension, one must also treat the uveitis. Therefore it has been impossible to avoid digression at times into the field of uveitis, to the apparent neglect of the subject under discussion, hypertension. The two points which need most to be emphasized are the avoidance of overlooking the existence of a chronic uveitis, where hypertension exists, in order not to make the erroneous diagnosis of chronic simple glaucoma; and the avoidance of delay in resorting to operative procedure, such as paracentesis or iridectomy, when other measures fail to control the hypertension.

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DISCUSSION

William A. Boyce, M.D. (1210 Roosevelt Building, Los Angeles).—Doctor Weymann has given us a very excellent presentation of chronic uveitis with hypertension. While he urges a thorough examination to find the focus of infection, if possible, he further states that if the hypertension is being controlled with other measures, it is better not to disturb the active focus of infection until the eye is quiet. In this I disagree, as I feel it is best to remove this focus as soon as possible, since frequently this is all that is necessary.

It may be quite true that a great many of these are due to tuberculosis, but it is very hard to demonstrate that they are. I often wonder, in the administration of tuberculin in these cases, whether or not you get the specific effect from the tuberculin or if you get the foreign protein effect.

In the measures to correct the hypertension I also disagree with Doctor Weymann regarding the iridectomy. Personally I have had very few good results from an iridectomy in cases of this kind and, in fact, it is seldom that any one operation will suffice. I would much prefer a trephine, repeated if necessary, which is frequently the case; or to do a trephine as the first operation and if this isn't successful, to do a cyclodialysis. Both the trephine and the cyclodialysis can be repeated several times.

I do not know of any condition about the eye that is more unsatisfactory to treat than this type of uveitis.

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C. Allen Dickey, M.D. (450 Sutter Street, San Francisco).—There are few diseases so disconcerting to the oculist as uveitis with hypertension. Fortunately, this is not a very common condition.

As an aid in the diagnosis I would like to emphasize the importance of taking the tension with a tonometer repeatedly, and of a thorough slit-lamp examination. In many cases the etiology is obscure, as it is difficult to evaluate one's findings; for example, a questionable positive tuberculin and also evidence of focal infection. Tuberculin therapy has been rather unsatisfactory in our experience, although we have not used the newer forms of tuberculin M A 100 and the A. O. vaccine.

I would like to mention two cases in which the treatment differed. In the first we attempted to control the disease with alternate constriction and dilatation of the pupil, using pilocarpin and suprarenin. However, synechiae formed and we had some difficulty in breaking these. The condition continued in spite of all therapy, both local and general.

In the second case, after the usual treatment had failed, we elected to do an iridectomy; and following this the patient has had only one temporary increase in tension, and the uveitis has subsided, with constant dilatation of the pupil.

While the lesser of two evils appears at first to temporize with medical treatment, I feel that rather thorough dilatation of the pupil is advisable; and if the hypertension continues in spite of the usual treatment, including paracentesis, then an iridectomy is the procedure of choice.

Doctor Weymann is to be congratulated on his presentation of this subject.

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Helen E. Preston, M.D. (1136 West Sixth Street, Los Angeles).—We are indebted to Doctor Weymann for clarifying the methods of diagnosis and treatment of a condition which may well be extremely puzzling. It has been my privilege to observe and study a number of cases such as he describes, at the Los Angeles County Hospital, treated by a variety of methods.

It may be of interest to present here a case whose management resulted in an entirely satisfactory conclusion. It was difficult to distinguish between a chronic or subacute primary glaucoma, and the hypertension secondary to a uveitis, which we are considering here. A slight blurriness of vision, excess lacrimation, and mild achiness had existed for six months. A very mild conjunctival hyperemia was present. The pupil was slightly larger than the unaffected eye, but reacted to light. The tension was 44 millimeters. hg. (Schiotz), and, most important of all, there were pigment deposits on the anterior lens capsule.

Miotics did no good in reducing the tension, whereas the use of adrenalin, either by pledget or by subconjunctival injection (3 minims), and of homatropin, was able to control it fairly well for a number of weeks. A field defect was beginning, and so operation was decided upon. A cyclodialysis was performed in January, 1934, by Professor Anton Elschnig, during his demonstration clinic in Los Angeles. The eye has been perfectly quiet since, with normal tension and normal vision.

Of course conclusions cannot be drawn from the outcome of a single case, but I feel that this procedure, if the full details of the Elschnig technique are observed, is a valuable one. Unless the inflammatory character of the disease is very pronounced, I do not believe that the trauma to the ciliary body is severe enough to make trouble. It is not meant to suggest this as a complete substitute for iridectomy, paracentesis, or trephine, but as a companion to these procedures, among which a choice is to be made.

COMPULSORY HEALTH INSURANCE*

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X

THE available evidence is overwhelming that the effect of compulsory health insurance on the German medical profession has been little short of disastrous. The literature on the question, mostly in the German language, is as impressive as it is often pathetic in its pessimism regarding the outlook for far-reaching reforms. As has been well said in an article in *Science* of October 12, 1934: "The medical profession in Germany has fallen into disrepute." . . . and "If present conditions are allowed to continue much longer, medicine will sink into a bog of absolute inefficiency."

THE TRAGIC ASPECT OF PANEL PRACTICE

In an extended article on the admission of physicians to panel-practice, by the Berlin correspondent of the American Medical Association (*The Journal of the American Medical Association,* August 16, 1934), the tragic aspects of the present situation are painted in gloomy colors. The profession is no longer free and independent, but the football of politics and political regimentation. Truly Bismarck was right when, in 1883, he observed that the establishment of compulsory health insurance was a step in the dark, and since then no modern Moses has been forthcoming to lead the bewildered profession into realms of security and undisturbed scientific advances typical of the golden days of freedom.

REASONS FOR THE IMPROVEMENT IN MEDICAL CARE IN GERMANY

Unquestionably, the situation as regards the medical care of the German people in the early eighties was deplorable, but so it was in every other highly industrial and highly urbanized country the world over. The death rate in most countries fifty years ago was between 25 and 30 per 1,000. A frightful toll was exacted by fatal epidemic diseases which, since that time, thanks to the progress of medicine and social well-being, has been reduced to negligible proportions in all but a few large and essentially primitive areas.

LATEST GERMAN STATISTICS ON COMPULSORY SICKNESS INSURANCE

The latest available figures for compulsory health insurance in Germany are for 1931. During that year the total membership in compulsory sick funds was 20,616,000, and these persons experienced 7,497,000 cases of sickness, representing 213,437,000 days of sickness. The total income of the funds was 1,607,834,000 marks, while the total outgo is given in the following table:

* One of a series of articles on compulsory sickness insurance written for California and Western Medicine by the well-known consulting statistician, Frederick L. Hoffman, LL.D. Articles in this series were printed in previous issues as follows: I, in April, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33; V, in August, page 114; VI, in September, page 177; VII, in October, page 262; VIII, in November, page 323; IX, in December, page 398.

TABLE 1.—*Expenditures of German Sickness Fund, 1931*

	Marks
Medical attention	383,604,000
Dentistry	90,366,000
Medical appliances, etc.	188,619,000
Hospital and institution care	276,207,000
Other material aid to patients	18,567,000
Cash benefits	389,599,000
Other cash to patients	25,181,000
Maternity benefits	98,536,000
Funeral benefits	19,694,000
Administration	158,632,000
Total	1,649,005,000

Thus it is shown that the German sickness funds represent a truly colossal financial undertaking involving an enormous bureaucratic machinery entering into every aspect of everyday life. To the insured, the money support is the major matter of interest; and this depends, of course, upon the medical certificate of incapacity for work. Since there is a certain amount of freedom of choice in the selection of doctors, those who are the most ready to give certificates on the slightest pretense of illness have a larger patronage and public support. The really conscientious physician who tries to save the fund from fraud has a hard time. The literature on the subject contains countless expressions of resentment at the indignities to which the profession is exposed in its efforts to deal honestly and fairly with the different parties interested in an economic administration. The most impressive expression of medical opinion is that of Dr. Erwin Liek of Danzig, who time and again has voiced the principal objections to the existing condition in unmistakable language.

COMPARISON OF MORTALITY STATISTICS FOR GERMANY AND THE UNITED STATES

In 1929, Doctor Liek published a booklet on social insurance and public health, from which I will quote some of the most important statements. Liek first calls attention to the problem of public health in Germany, as measured by an increase in the average expectation of life from twenty years in the seventeenth century, to thirty years in the eighteenth century, to forty years by 1870, to fifty years by 1910 and to sixty years at the present time. He states that the death rate in Germany declined from 29.6 per 1,000 in 1871 to 11.6 in 1928; but a similar decline has taken place in nearly every country under modern public health administration without reference to any social insurance which cannot rightly claim a predominating share in the results achieved. In the United States, for example, in 1933, the death rate for the entire country was 10.7 per 1,000 of population, or the lowest on record, and lower than that of Germany and England and Wales at the present time. In other words, our own public health progress has been as great, if not greater, without health insurance than that of Germany, and certainly so in many matters of important detail, such as the suppression of typhoid fever, diphtheria, etc.

SOME DEPLORABLE RESULTS FROM COMPULSORY SICKNESS INSURANCE

Liek is of the opinion, quoting an expression at the German Surgical Conference in 1928, that the insured has lost the desire to get well, and is very often opposed to remedial measures which would cause a loss of the money benefits payable under health insurance. He also expresses the opinion that higher wages and good housing conditions are much more important for the general population than health insurance, which squanders enormous sums of money that could be used for much more important health-promoting purposes. He calls attention to the fact that frequency and duration of sickness under health insurance increases, while the contrary should be expected. In Germany, at that period, every insured person was sick, on the average, twice a year, and every second insured was reported sick and incapacitated for work!

In Aachem, a Doctor Webber, director of the local sickness fund, reported in 1928 that, of one thousand insured only sixty-five failed to make use of the sick fund during the year. He made the statement at the time that thirty-five million insured paid four times as much for medicine as thirty million not insured. He quotes the Federal Health Department as having determined that the average sick fund patient required three times as much medicine as the private patient.

COMPULSORY SICKNESS INSURANCE MAKES FOR MORE ALLEGED SICKNESS

Liek estimates, on the basis of existing data, that sickness-frequency among non-insured is about 20 per cent annually, while that of the insured exceeds 200 per cent. In brief, he maintains that every new insurance provision, and every new clinic or institution, is merely a means of increasing alleged sickness among the German population. He quotes from the Hamburg-South America Line reports that they recently established a sickness fund for seamen, and that out of 2,800 employees, 60 per cent reported themselves sick during the year while, previous to the establishment of the sick fund, only 250 men reported themselves sick, or not as much as 10 per cent.

Liek likewise quotes from the annual report of the Hamburg-American Line that the number of sickness cases among its employees was four to five times greater under the more liberal provisions of sickness insurance. He also draws attention to a remark by Prime Minister Ramsay MacDonald, to the effect that the more liberal the unemployment insurance, the greater is unemployment.

RÔLE OF RHEUMATISM IN SECURING SICKNESS BENEFITS

Abuses too numerous to deal with in detail are referred to in various publications, mostly all to the effect that the misuses of the system far outweigh its public utility. The waste of medicine must be enormous. The principal disease for which treatment is required is rheumatism, of

which a large proportion is claimed to be false pretense. Liek quotes from a treatise by Webber that in many sections of Germany from one-sixth to one-half of all employees during the year require treatment for rheumatism. In marked contrast he calls attention to the comparative rarity of rheumatism among uninsured persons. In other words, rheumatism is a mere pretense for collecting cash benefits during alleged illness of long duration, falsely certified as such by easy-going attending physicians.

RELATION OF SICKNESS CLAIMS TO UNEMPLOYMENT

In 1927, the association for German sickness funds printed advertisements in all the leading papers under the heading "Parasites and the Sickness Fund," stating that of 7,918,000 insured in 1926, 1,259,000 alleged patients or about 16 per cent, were required to submit to a reëxamination. Of these, 198,000 failed to appear before the examining physician, but reported themselves as well and fit to go to work; 219,000 likewise permitted themselves to be determined as being in good health, while 293,000, in subsequent examinations, were found to be fit for employment. Of the examined, therefore, 56.5 per cent were found to be entirely fit for work and guilty of malingering or downright imposition upon the fund. If the attending physician is required to spend most of his time on such parasites or pretenders, he cannot make proper allowance for deserving patients. The experience is universal that during periods of unemployment the demands upon the sick fund rise at once, and continue at a maximum figure as long as unemployment conditions remain difficult.

EXTRA COST RESULTING FROM REËXAMINATIONS

In consequence of this state of affairs, the number of the reëxamined increases from year to year, involving additional expense and serving no useful medical purpose. In Nuremberg, for example, in 1927, of 141,299 insured, more than 91,000 were required to be reëxamined. Hence, an atmosphere of apprehension and mistrust has developed and become characteristic of the whole system of sickness insurance. The astonishing claim is made, on the basis of apparently trustworthy statistics, that two-thirds of the cash benefits drawn by members are wrongfully obtained as the result of malingering, imposition and fraud. The only protection the sickness fund has against such imposition is reëxamination of patients, with the result, as stated; but the members of the sick fund are determined to derive some benefit from their contributions, properly or improperly as the case may be.

INCREASING COMPLEXITY OF COMPULSORY SICKNESS INSURANCE IN GERMANY

From year to year sickness insurance in Germany has grown more complex, and rules and regulations have become enormously complicated. While in Norway sickness insurance laws consist of forty-four paragraphs or sections, in Switzerland of forty-two, in Belgium of sixty-four, those of Germany consist of 372. Hence the conclusion that the intricacies of this bureaucratic machinery have established an impossible undertaking, and that the chief objective of proper medical care of the insured is lost sight of. According to Liek, in 1928 social insurance in Germany cost 5,245,000,000 gold marks compared with 1,037,000,000 in 1913. It is said that at the present time there are 4,500,000 insured annuitants, aside from 1,500,000 entitled to annuities because of the war; and according to a statement at a recent medical meeting in Germany, one in every seven of the adult population is an annuitant. In Danzig, at the present time, it is estimated that every two families at work support a third family out of work. or alleged to be ill.

COMPULSORY SICKNESS INSURANCE INCREASES RATHER THAN DECREASES CLASS ANTAGONISMS

Brought into existence to overcome Socialist agitation and to give aid and comfort, the Socialists who, at the beginning, were opposed to the system, are now its strongest advocates. Instead of diminishing class antagonism, it has gone far to increase it, while the workman has obtained a totally false conception of the system, now looked upon as a general social welfare institution without economic principles based on sound economic laws and past economic experience. Politics enter into the system, and benefits promised or paid are the spoils of the different political parties, all bidding for support of the insured on the ground of further benefits unearned and undeserved. This, of course, has reference to the situation previous to the establishment of the Hitler régime, which may possibly bring about reforms on a large scale by mere fiat and dictatorship.

EFFECT OF COMPULSORY SICKNESS INSURANCE ON THE SPIRITUAL LIFE OF A PEOPLE

What Liek deplores most is the disastrous effect of compulsory health insurance on the spiritual life of the German people. It has corrupted the German mind, to an appalling degree of obtuseness, to sound principles in political and social relations. The aim is to get all the benefits possible out of the system irrespective of the effect on the national budget. Increased contributions are resented, and the chief burden is shifted to the employer on the one hand and the taxpayer on the other.

WHY INSURED PERSONS PREFER TO REMAIN INVALIDS

It is the consensus of qualified medical opinion in Germany now that the insured person is much more difficult to treat than the uninsured, who desires to get well while the insured prefers to remain an invalid as long as his annuity or sick benefit continues. In acute diseases, it is said that in the case of the uninsured, two weeks of treatment suffice, while it has required from four to six weeks for treatment of the compulsory insured. Hence, the astonishing conclusion that the desire to get well is wanting among the insured, who become accustomed to a parasitical dependence upon unearned benefits derived from sick funds on one pretense or another.

IN GERMANY THE INSURED PERSON AND THE PHYSICIAN ARE BOTH IN BONDAGE TO THE GOVERNMENT

I conclude these observations on the German situation with a statement recently published in the Philadelphia *Daily News* by H. R. Knickerbocker, a well-known foreign correspondent. He gives the following table of taxes, dues and contributions of one sort or another paid by the German workman at the present time out of a slender income which, in seven hours, is said to produce a wage only equivalent to that earned in the United States for the same kind of labor in two hours:

TABLE 2.—*Insurance and Taxes Paid by the German Workman Today*

	Reichsmark
Income tax	2.10
Old-age insurance	1.20
Citizens' tax	1.25
Sickness insurance	1.20
Unemployment insurance	1.30
Tax for aid unemployment	.80
Bachelor tax	2.10
German work-front dues	1.50
	11.45

Thus the wage earner is in bondage to the government as much as is the insurance physician, and both are confronted with an apparently hopelessly confused problem which only a social revolution can possibly change.

THE LURE OF MEDICAL HISTORY*

THE INFLUENCE OF CLAUDE BERNARD ON MEDICINE IN THE UNITED STATES AND ENGLAND†

By J. M. D. OLMSTED, Ph.D.
Berkeley

I

DURING the nineteenth century no medical student in the United States felt that he had really completed his studies until he had visited the hospitals and laboratories of Europe. It has been suggested that on account of the bitter feeling towards England after the Revolutionary War, and especially after the War of 1812, few of these young physicians cared to study in England. It was Paris that attracted them, and this in spite of Claude Bernard's complaints regarding the poor facilities for medical research in France, and his covetous glances at the well-equipped laboratories of Germany.

When Bernard came to Paris in 1834 as a youth of twenty-one and abandoned a literary career to take up medicine, the famous clinician, Louis, was attracting students from all over the civilized world. Osler names nearly forty Americans, including Oliver Wendell Holmes, who crossed the Atlantic to study with this brilliant physician during the years 1830 to 1840. Bernard did not really become known in the medical world until about 1847, when he began to lecture at the Collège de France as substitute for Magendie, the aging Professor of Medicine. From 1850 on, his lecture demonstrations attracted foreign students as had the lectures and clinics of Louis two decades before.

BERNARD'S INTEREST IN THE BEAUMONT EXPERIMENTS

Bernard's reputation in 1850 is shown in a letter from an Illinois physician, Willis Green Edwards (who died in 1862), to William Beaumont, the pioneer American physiologist. Edwards was in Paris and he wrote to Beaumont of Bernard's interest in the experiments Beaumont had performed on Alexis St. Martin, and of Bernard's desire to know what had happened to St. Martin later in life. He said: "Your experiments are constantly imitated here by a large number of investigating physiologists, among whom M. Bernard probably stands first." It is worth while adding the comment of Beaumont's biographer: "The interest manifested by Bernard evidently rekindled the old spark of ambition and zeal, and prompted him to reopen correspondence" as to the whereabouts of his erstwhile patient, in order to get in touch with him for more experimentation.

At the time of Bernard's death in 1878, Austin Flint, Jr. (1836-1915), who had met Bernard in 1861, wrote in the *American Journal of the Medical Sciences:* "He was visited by nearly all physicians who went from this country to Europe to study disease in the hospitals. We now have in mind the remembrance of accounts given us by old practitioners of medicine of the wonderful dexterity in experimentation, of the unvarying affability and the patient and kind attention always given to strangers by the great French physiologist."

BERNARD'S WORK IN ANIMAL EXPERIMENTATION

One must remember that Bernard was an experimental physiologist, not a practicing physician, and that his operations and treatments were made upon dogs and rabbits, not on human patients. Indeed, his insistence upon rigidly controlled experiment, as the very foundation of medicine, at first alienated certain members of the profession. Later, however, all were to realize that Bernard's whole life had been spent in an attempt to bring medicine nearer to the goal of being a true science.

HIS INFLUENCE ON WEIR MITCHELL, DALTON AND DONALDSON

One of the first young physicians to be profoundly influenced by Bernard was Silas Weir Mitchell (1829-1914), who came to be famous not only for his rest cure, but also for his novels

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department of CALIFORNIA AND WESTERN MEDICINE, and its page number will be found on the front cover index.

† From the Division of Physiology, University of California Medical School, Berkeley.

and verse. Weir Mitchell's father was a professor in Jefferson Medical College, Philadelphia; and after the son had graduated from this institution in 1850, he spent a year in Paris, returning in the fall of 1851. He writes: "I took courses designed for surgical training, but I liked better the lessons of Bernard in physiology and Robin in microscopy. I recall one remark of Bernard's. I said, 'I think so and so must be the case.' 'Why think,' he replied, 'when you can experiment. Exhaust experiment, and then think.'" Upon his return home, Mitchell continued his researches, and in 1860 published an article on the venom of rattlesnakes. This problem was evidently started under Bernard, for the latter was working on this subject at the time Mitchell was in Paris, and only the year before had given a report before the Société de Biologie on the physiological action of venoms. In one of his lectures during the winter of 1859-1860, Bernard showed his class two samples of poison and said, "The properties of these poisons have been so well studied by M. Mitchell of Philadelphia."

This same year, another youth, whose obituary notices were to be written by Weir Mitchell half a century later, came under the spell of Bernard's teaching. John Call Dalton (1825-1889), received his M. D. from Harvard in 1847, and taught physiology for a year in Boylston Medical School (Boston), then at Buffalo, before going to Paris in 1850. When he returned to Buffalo and later, when he became professor of physiology in the College of Physicians and Surgeons in New York City, he showed that he had brought back with him not only the spirit of Bernard's teaching but also the method; for it is claimed that he was the first in this country to teach physiology by vivisection. When Bernard began to publish his lectures in 1855, it was Dalton who reviewed the first volumes in the *American Journal of the Medical Sciences,* prefacing the review with the following statement: "It may be truly said that M. Bernard has inaugurated a new epoch in experimental physiology. He has first placed the science on its true footing, and has indicated the only true course, that of experimenting on living or recently killed animals." In 1867 Dalton made a gallant defense of this method of arriving at the facts of physiological science in a pamphlet published under the auspices of the New York Academy of Medicine and entitled, "Vivisection: what it is, and what it has accomplished." In it he cites certain experiments of Bernard's. It might also be mentioned that Dalton's Treatise on Human Physiology, the first edition of which appeared in 1859, went through many editions, and in the 1880's was the most widely used textbook on the subject in the United States. Needless to say, description of Bernard's experiments occupies several pages, and in one place is accompanied by the remark, "the most important of which (*i. e.,* Bernard's experiments) we have repeatedly confirmed."

A third young American in Paris at this time, Francis Donaldson (1823-1891), who obtained his M. D. from the University of Maryland in 1846, sent back to the United States a digest of Bernard's lectures of 1850-1851. This was published at once in the *American Journal of the Medical Sciences.* Donaldson also was particularly impressed by the demonstrations on living material. He wrote: "It was curious enough to see walking about the amphitheatre of the College of France dogs and rabbits, unconscious contributors to science, with five or six orifices in their bodies from which, at a moment's warning, there could be produced any secretion of the body, including that of the several salivary glands, the stomach, the liver and the pancreas."

RECORD OF BERNARD'S WORK IN THE LITERATURE

Because many of the quotations above are taken from one American medical journal, the *American Journal of the Medical Sciences,* it must not be thought that it was the only one to report Bernard's lectures and discoveries. The following is a quotation from the Paris letter of the foreign correspondent, A. B. Hall, to the *Boston Medical and Surgical Journal* for November, 1853: "The lessons given at the College of France, during the summer session of 1853, by M. Claude Bernard, suppliant of M. Magendie, were exceedingly interesting. I will give you some of his remarks upon gaseous absorption." The letter ends, "But more anon. Respectfully, A. B. H."

Abstracts in medical journals, therefore, gave American physicians access to Bernard's latest researches, but one young man, Walter F. Atlee (1828-1910), M. D., University of Pennsylvania, 1850, after attending Bernard's lectures on blood in 1853-1854, felt that these lectures should be made known to the profession *in extenso.* He therefore asked permission to publish his notes on his return to Philadelphia. The book appeared in 1854. He evidently made few changes in his notes, for they read as if one were listening to Bernard talking. Sometimes the English is a literal translation of the French, as, "in summer when destruction marches rapidly"; sometimes there are comments, as, "M. Bernard promised to make some researches, and to give the results before the close of the course, but he never again referred to it." It is an interesting fact that this was the first series of Bernard's lectures to appear in book form, and that it should have been published in the United States and in English.

Perhaps better known to American medical practitioners than his *Leçons* was the "Treatise on Operative Surgery," in which Bernard wrote in collaboration with Ch. Huette in 1848. This work was translated into English by William Horne Van Buren (1819-1883),who came of a long line of physicians, his great-grandfather having been a pupil of the famous Dutch teacher, Boerhaave. He had spent some time in France after his graduation in medicine from the University of Pennsylvania in 1840, but it is improbable that he knew Bernard. Van Buren's translation appeared in 1855, and the notice in the *American Journal of the Medical Sciences,* signed E. H.,

praised it in the following terms: "It is unquestionably the handsomest compendium of operative surgery that has yet appeared, and, withal, so compactly as well as clearly arranged, that we are inclined to think that it may prove even more useful than it is ornamental. With the best wishes for the success of a publication which does the highest honour to good taste, enterprise and judgment of all concerned, we most cordially recommend it as on all accounts worthy of a prominent place in every medical library, or on every office table." This book was furnished to army surgeons by the United States Government during the Civil War.

OTHER AMERICAN PHYSICIANS WHO STUDIED UNDER BERNARD

During the years 1845-1865, when Bernard was most active, there were nearly one hundred American physicians whose short biographies in Kelly and Burrage's American Medical Biographies show that they continued their medical studies by a year or so in France. In only a very few instances, however, is it specifically stated that the individual actually worked under Bernard, but we can add to the list of those already mentioned the names of Alfred L. Kennedy (1818-1896), who was with Bernard in 1848, immediately after obtaining his M. D. from the University of Pennsylvania, and William H. Mussey (1818-1882), who graduated from the Medical College of Ohio in 1848, and was with Bernard in 1851. The American students in Paris formed a society which they called the American Medical Society of Paris, and Mussey was elected its president during the year that he was there.

BROWN-SÉQUARD'S RELATION TO BERNARD

No list of those who brought Bernard's teaching to America, however abbreviated, should omit the name of that roving genius, Brown-Séquard (1817-1894), who moved back and forth between France and the United States like a shuttle in a loom. Posthumous son of an American father by a French mother, he had completed his medical studies in Paris under the greatest handicaps in 1846, and, like Bernard, had attempted to do experimental work in out-of-the-way holes and corners. He is reported to have lived in a garret with no stove to alleviate the dank chill of the Parisian winter, while hutches of rabbits and guinea-pigs contaminated the atmosphere. Bernard refers to Brown-Séquard as one of those physiologists who had to leave France because of lack of support in his chosen profession. In 1852 he thought he might fare better in his father's native land, and took passage in a sailing boat for the United States. He purposely chose so slow a vessel in order that the length of the voyage might permit him to learn English. Under the patronage of distinguished physicians in Boston, New York, and Philadelphia, he lectured on the discoveries of Magendie and Bernard, and even performed some original experiments. He returned to France, but in 1855 accepted for a short time a professorship at the Virginia College of Medicine in Richmond. Again he crossed the Atlantic, only to return once more to hold for a brief three years (1864-1867) the professorship of the physiology and pathology of the nervous system at Harvard. Unfortunately, Brown-Séquard did not remain long enough in this country to be instrumental in doing for physiology here what Bernard was doing for that science in France, though he was considered worthy to succeed Bernard as professor of medicine at the Collège de France in 1878.

(To be continued)

CLINICAL NOTES AND CASE REPORTS

SUCTION APPARATUS FOR BLADDER OR DUODENAL DRAINAGE

By H. H. Parsons, M. D.
Grass Valley

MANY different kinds of apparatus are in use throughout the country for the creation of mild continuous suction such as is used in suprapubic bladder or duodenal drainage. They consist, for the most part, of bottles, old syringes and rubber tubing, and very often are makeshift affairs, not understood by the nurses, so that the surgeons frequently need to refer to diagrams in order to construct them.

In order to overcome these disadvantages, I constructed and have used, for the past four years, the apparatus described below. It is inexpensive, efficient, requires little storage space, and is always ready for use.

It is made from the following parts, and connections may be provided by soldering or threading the various parts, as shown in the diagram:

A —Hollow brass wire, $\frac{3}{16}$ inch outside diameter, 2 inches long.
B —Copper tubing ¼ inch outside diameter, 36 inches long.
C —Hollow brass wire $\frac{3}{16}$ inch outside diameter, 32 inches long.
C′—Copper tubing ¼ inch outside diameter, 10 inches long.
D —Brass tubing ¾ inch outside diameter, 6½ inches long.
E —Copper tubing ¼ inch outside diameter, 1½ inches long.
F —Brass "T."
G-G′—Brass plugs, threaded and shaped as shown in diagram.

The parts are assembled and made air-tight by soldering, and the tubes *B* and *C* may be soldered together for rigidity.

For use, the apparatus is lashed to the upright of an irrigator stand, so that the lateral, *E*, is on a level with or below the point to be drained. Rubber tubing connects *E* to the drainage point. The intake, *A*, is connected to an irrigator can by means of rubber tubing, and the flow is controlled by a Hoffman cutoff. A Murphy drip glass may be inserted in the line if desired. Rubber tubes are connected to the distal ends of *B* and *C*, and their free ends immersed in water in separate vessels on the floor.

By filling the irrigator can and partially emptying the two floor receptacles occasionally, continuous suction is maintained.

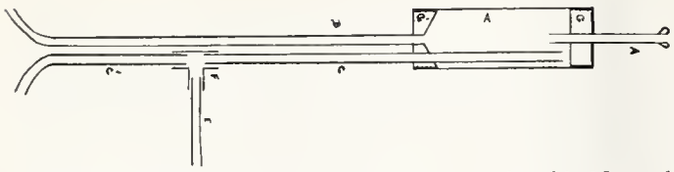


Fig. 1.—Diagram of suction apparatus for bladder of duodenal drainage.

A —Hollow brass wire $\frac{3}{16}$ inch outside diameter, 2 inches long.
B —Copper tubing ¼ inch outside diameter, 36 inches long.
C —Hollow brass wire $\frac{3}{16}$ inch outside diameter, 32 inches long.
C'—Copper tubing ¼ inch outside diameter, 10 inches long.
D —Brass tubing ¾ inch outside diameter, 6½ inches long.
E —Copper tubing ¼ inch outside diameter, 1½ inches long.
F —Brass "T."
G-G'—Brass plugs, threaded and shaped as shown in diagram.

The water dropping from *A* through *D* leaves by way of *B*, thus creating a partial vacuum in *D* and *C*, but the lower end of *C'* being submerged the suction is made manifest in *E*, which is connected to the site to be drained. Fluid entering *E* runs down the lower part of *C'* and does not go up into *D*.

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EPIDIDYMITIS—SOME CLINICAL OBSERVATIONS

By Clayton Lane, M. D.
Los Angeles

THERE are several valuable points of clinical interest to the general surgeon and clinician relative to acute and chronic inflammatory reactions within the epididymis. It would be only a reiteration of known knowledge to classify the several types and enumerate the usual textbook symptomatology; and my purpose, therefore, in this short paper is to draw attention to a few outstanding features relative to epididymal inflammations, trusting that they may be of some value in the office or at the bedside.

Clinical practice seems to reveal the fact that support, properly applied, is more important in promoting resolution of inflammatory conditions of the epididymis (non-tubercular) than any type of local application one may use. Smearing the scrotum with black, glycerinated concoctions promises little, except a black and messy dressing.

The following adhesive plaster dressing may be tried: Use an ordinary gauze flat, roll it (tightly) lengthwise like a cigar and run a strip of plaster, one-half inch wide, around and down the length of it, similar to the "barber pole" stripe. This will keep the gauze from unrolling. Tear off a strip of plaster, one inch wide and about eight inches long, and lay the gauze-roll lengthwise and in the center of the adhesive side of the strap. Lay the scrotum flat upon the abdomen and strap the gauze-roll in place, transversely across the perineum and behind the testicles, running the ends of the adhesive plaster up to either groin and thus forming a sling, behind which the testicles will not slip, as the gauze-roll acts as a barrier. Next, strap the scrotum and contents against the abdomen with two-inch adhesive, applied transversely. Do not worry about the dressing impeding the act of urination, as the patient will manage satisfactorily. Add new supports to this dressing as needed. Immediate cessation of pain and the ability to get around actively is the result that may be expected from this treatment.

Examine the cord frequently in cases of acute epididymitis. A "pipe stem" sensation imparted to the examining fingers points to funiculitis of the cord. It is best not to play tag with this condition. Open up the scrotum, free the fascia about the cord well up to the external ring, slit the epididymal sheath, drain freely with penrose through the lower end of the scrotum and sew up the original incision with black silk. Temporize with this condition and abscess of the testicle with resultant orchidectomy will be your penalty.

Persistence of marked epididymal swelling after ten days, pain and soreness failing to subside early, temperature persisting after five days—any or all of these signs in evidence means epididymal, and possibly testicular abscess, and diagnoses a surgical scrotum. Do not drain an acute eipdidymitis that reveals pus. Do an epididymectomy.

Always explain to the patient, preoperatively, that the testicle may be abscessed and a removal of the same may be necessary, so that your endeavor to do conservative surgery upon an epididymis, showing pus, will leave you a loophole through which you may sneak back later and do an orchidectomy, because ten chances to one that is precisely what you will have to do. Drainage of the acute epididymis by early multiple punctures may be all right, but if you find any pus in those needle holes, then remove the epididymis at once.

In dealing with epididymitis in the elderly individual, do a bilateral vasectomy. I believe that severing the vas, especially on the affected side, will break the continuity for absorption from the vesicle and prostatic area.

There are two points to bear in mind in doing scrotal surgery for tuberculosis. First, considering the frequency of tuberculosis in other parts of the body, in patients with scrotal tuberculosis you must prepare yourself to combat a rapid flare-up of some other tubercular rest following your scrotal surgery. As a popular cartoonist puts it: "They'll do it every time." Perhaps not every time, but sufficiently frequent to keep one busy enough. You may think that ligation of the vas, high up, and cauterization will prevent this distressing aftermath; but sad experience has taught me the fallacy of this theory. Such procedure is important and necessary, but do not be surprised if things happen to cause much concern later on.

The second point to which I wish, in conclusion, to call attention to is closure in scrotal surgery for tubercular conditions. Leave the scrotum wide open and pack with iodoform gauze. Expect a sinus, or perhaps two or maybe three; then, if your patient surprises you and heals without a sinus, you will be happily disappointed.

1052 West Sixth Street.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

HEADACHES

I. ETIOLOGY

J. M. Nielsen, M.D. (*727* West Seventh Street, Los Angeles).—The term "headache" is not well defined. Most patients distinguish between headache and a pain in the head, the former being as a rule a duller sensation, the latter rather a sharp pain; yet a neuralgic headache is a common clinical complaint. Some patients consider a headache a pain arising within the cranial cavity, yet migraine headaches frequently extend "down the neck and into the shoulder." The so-called indurative headaches are due, not to an intracranial condition, but to fibromyositis at the sites of insertion of the neck muscles into the base of the skull. We are, therefore, forced to take a broad view and discuss in the etiology of headache those conditions which cause discomfort about the head, commonly complained of as headache.

Headaches due to many causes, until recently obscure, have been clarified by the work of Kennedy on angioneurotic edema of the brain,[1] of Forbes and Wolff,[2] Cobb and Finesinger,[3] Chorobski and Penfield,[4] and Finesinger,[5] on anatomy, physiology, and pharmacology of the cerebral circulation. There is no longer any question that vasomotor nerves play a great part in cerebral circulatory adjustments. That such circulatory changes, when marked or extreme, may cause headache, is admitted.

All headaches may be considered due to one or more of the four following pathological states, or to an unknown cause:

I. Change in intracranial pressure.
II. Pathological anatomy or physiology essentially extracranial but causing headache reflexly.
III. Toxemia.
IV. Meningeal irritation aside from expansion.
V. Unknown. Here we are still forced to include many cases of migraine.

I. Change in Intracranial Pressure:

1. *Increase in Intracranial Pressure.*

(*a*) Obstruction of venous circulation. Thrombosis of cerebral sinuses, or of cerebral veins; presence of venous aneurysms, polycythemia vera.

(*b*) Increased blood supply through the arteries by dilatation; reflex because of medullary anemia, as in acute head injuries; some cases of migraine, many functional states, particularly pyschoneuroses.

(*c*) Stasis in cerebral blood vessels, as in lowering of the head, in inversion of the body, or jugular ligation.

(*d*) Obstruction of cerebrospinal fluid circulation causing hydrocephalus. (1) Lesions at foramina of Monro; blood-clot, tumor of the third ventricle, and aneurysm. (2) Lesions within the third ventricle: tumor or blood-clot. (3) Lesions at the midbrain. Tumor of the pineal body, corpora quadrigemina, or immediate vicinity. Obstruction of the aqueduct by blood-clot or by chronic meningitis or ependymitis, syringobulbia during stage of gliosis. (4) Lesions at the fourth ventricle. Obstruction of the foramina of Luschka, or foramen of Magendie, by fourth ventricle tumors especially in children, other cerebellar tumors, tumor or abscess of the cerebellopontine angle, chronic leptomeningitis whether non-specific or due to tuberculosis, syphilis, coccidioidal or other chronic granuloma, torula, or the common epidemic organism. It may result from arachnoiditis, following intraventricular hemorrhage. (5) Lesions at the base causing "communicating hydrocephalus."

(*e*) Increase in size of cranial contents aside from those caused by increase in blood or spinal fluid. (1) All tumors which do not actually replace brain tissue. (2) Brain abscesses of all types and sources. (3) Localized hemorrhages, especially subdural hemorrhages. (In infancy this may give rise to external hydrocephalus.) (4) Nonpurulent inflammatory conditions of the brain. Encephalitis preliminary to abscess or of the epidemic type, or encephalitis secondary to vaccination, measles, mumps, scarlet fever, or due to lues, tuberculosis, parasitic infection, otitis media, or in fact secondary to any acute infectious disease. (5) Edema as in uremia, acute head injury, serum reactions, angioneurotic or urticarial edema. The various generalized infectious diseases may cause edema of the brain, as may acute intoxications of which that due to alcohol is an example. Allergic sensitization may cause edema. Certain edemas are of unknown origin, such as that of epilepsy. (6) Increased pressure, secondary to acute increase in blood pressure, fear, anxiety, worry, and mental depression. Chronic hypertension is also frequently associated with headache.

2. *Decrease in Intracranial Pressure.*

(*a*) Arachnoidal tears within the spinal canal, as from trauma or dural incision from a spinal puncture, with continual drainage. Headache oc-

1 Kennedy, F.: Cerebral Symptoms Induced by Angioneurotic Edema, Arch. Neurol. and Psychiat., 15:28-33 (Jan.), 1926. Reported three cases before the Amer. Neurol. Soc., Washington, May, 1925.

2 Forbes, H. S. and Wolff, H. G.: Cerebral Circulation—The Vasomotor Control of Cerebral Vessels, Arch. Neurol. and Psychiat., 19:1057-1086 (June), 1928.

3 Cobb, S. and Finesinger, J. E.: Cerebral Circulation—The Vagal Pathway of the Vasodilator Impulses, Arch. Neurol. and Psychiat., 28:1243-1256 (Dec.), 1932.

4 Chorobski, J. and Penfield, W.: Cerebral Vasodilator Nerves and their Pathway from the Medulla Oblongata, Arch. Neurol. and Psychiat., 28:1257-1289 (Dec.), 1932.

5 Finesinger, J. E.: Cerebral Circulation—Effect of Caffeine on Cerebral Blood Vessels, Arch. Neurol. and Psychiat., 28:1290-1325 (Dec.), 1932.

curs during withdrawal of fluid, in preparation for a ventriculography or encephalography.

(*b*) Shock (the decrease in pressure being due to accumulation of blood in the splanchnic area), sudden hemorrhage, syncope, and certain emotional states.

(*c*) Arterial spasm (position in outline doubtful).

II. Extracranial Pathological Anatomy and Physiology, Causing Reflex Pains:

(a) *About the eyes.* (1) Errors of refraction. (2) Excessive use of eyes. (3) Attempts to focus on moving objects. (4) Alternating strabismus. (5) Excessive or insufficient convergence. (6) Muscle imbalance.

(b) *About the ears.* (1) Otitis media. (2) Mastoiditis. (3) Wax impaction. (4) Foreign bodies in canals. (5) Infectious sinus thrombosis.

(c) *About the nose and mouth.* (1) Septal contact. (2) Turgescence of the turbinates. (3) Ethmoiditis. (4) Sphenoiditis. (This gives a characteristic headache over and above the ears, and toward the mastoid region.) (5) Maxillary sinusitis. (6) Frontal sinusitis. (7) Foreign body. (8) Infected teeth. (9) Impacted teeth.

(d) *About the throat.* (1) Nasopharyngitis. (2) Eustachian salpingitis. (3) Retropharyngeal abscess. (4) Glossopharyngeal neuralgia. (5) Infected or impacted teeth.

(e) *About the cranium and scalp.* (1) Osteomyelitis of the skull. (2) Osteitis; luetic, tuberculous, osteitis deformans, leontiasis ossea. (3) Periostitis. (4) Fibromyositis about the insertions of muscles at the base of the skull—indurative headache. (5) Occipital nerve neuralgia or neuritis—not true headache. (6) Supra-orbital neuralgia—not true headache. (7) Malignant metastasis to the cranium and scalp.

(f) *Distant organs.* (1) Distended rectum. (2)Ovarian disease. (3) Hepatitis. (4) Enteritis. (5) Also practically any visceral infection may cause headache in certain persons. (6) Certain states of some organs not constituting disease. For example, in some cases hunger alone is sufficient.

III. Toxemia Causing Headache:

1. *Acute Toxemias.*—Almost any acute toxemia. This includes acute infectious diseases, intoxication with drugs, chemicals, fumes, etc. Worthy of special mention are: alcohol, tobacco, mercury, lead, arsenic, many sedative drugs (especially of the barbituric compounds), carbon monoxid, many fumes as hydrocyanic acid, chlorine, sulphur dioxid, carbon disulphid. There are many others. Of acute exogenous bacterial exotoxins tetanus, diphtheria and botulism are important. Food poisoning is worthy of mention.

2. *Chronic Toxemias.*—Intestinal toxemia (nature unknown), exposure to toxins or fumes in occupations.

IV. Meningeal Irritation:

(To list all causes of meningeal irritation would be to repeat many of the causes mentioned above which operate through this channel.) The most pertinent causes are: Meningitis of all kinds (remember syphilis), meningeal irritation without an actual meningitis; especially to be remembered is that due to brain abscess, sinusitis, pneumonia, typhoid fever, and other acute infectious diseases, and to blood in the subarachnoid space.

V. Unknown:

Space does not permit an analysis of the subject of migraine. Psychic, emotional, endocrine, chemical, physical, and pharmacologic factors all play a rôle.

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II. OCULAR CAUSES OF HEAD PAINS

Roderic O'Connor, M. D. (450 Sutter Street, San Francisco).—It is the common belief among the general public, and not very uncommon among medical men that if headaches and other symptoms of eyestrain are not relieved by glasses nothing further can be done. It is only in this way that we can excuse the frequency with which patients are referred by them to non-medical examiners for ocular examination. In doing so, such practitioners apparently forget that an examination of the ocular apparatus is as much a medical affair as one of the heart or lungs. The percentage of headaches due to ocular disturbances is difficult to determine, but probably seventy is a fair estimate. It is evident that the frequency with which the eyes are proved to be the cause will depend on the completeness of the ocular examination, the correct interpretation of findings and the proper carrying out of the right treatment.

Many patients show nothing wrong by ordinary tests, and yet there is definite eye disability. Most of these, by more detailed study employing prolonged monocular occlusion, turn out to be cases of hidden imbalance of the extra-ocular muscles. Some are of mild or beginning glaucoma. The importance of always having in mind the possibility of glaucoma cannot be overemphasized. The frequency with which eyes are blinded by this disease is a sufficient reason, in itself, to serve as a cause for prohibiting the examination of eyes by non-medical individuals. Many eye headaches are typically migraine, as far as the symptoms are concerned. The fact that it may be hereditary has no diagnostic significance, as ocular defects are even oftener so. Neither does vomiting indicate true migraine, as nausea, with vomiting, is a rather common symptom of certain forms of eye trouble. I have frequently seen the scintillating scotoma of migraine (supposedly) disappear after relief of eyestrain.

Most patients are able definitely to relate their headaches to overwork of the eyes; others cannot but state that it is present all day except on waking. Early morning headaches are more often nasal in origin. Women complain of shopping headaches. Many have them on cars or automobiles, or under other conditions where the eyes must follow moving objects. These are usually found to have disturbances of the ocular muscles, the compensation for which is especially difficult when the eyes are in motion.

While the consideration of intracranial pressure is out of place, it must be remembered that its diagnosis is often first made by the ophthalmologist while investigating headache. To show the harm done by non-medical eye care, I can state that I have seen three patients with brain tumor, all of whom lost their chance for life because of the delay incidental to the trying of many pairs of lenses, muscle exercises, or both, by non-medical examiners.

Pains in the base of the skull and upper cervical region are frequently of ocular origin, the causes usually being those conditions that call for a change in the position of the head to compensate, such as oblique astigmatism, vertical deviations, cyclophoria and the various forms of paralysis of the ocular muscles.

It should be concluded, therefore, (1) that the ocular apparatus must be completely studied in all cases of headache where the cause is not very evident. Frequently women come for eye examination after much gynecologic surgery, when the cause is quite easily located in the eyes. I never cease to wonder at the common failure of general men to check over first the seat of the pain. (2) That no physician should allow his treatment of a patient with headache to be influenced by the failure of an ordinary refraction to locate its cause. Refraction is but the beginning of a complete examination.

CLASSIFICATION OF CAUSES

A. Refractive errors.

B. Extra-ocular muscle imbalances.

C. Pupillary asthenopia—glare.

D. Increased intra-ocular pressure.

E. Inflammatory conditions.

A. Refractive errors are well-known causes, so therefore only a few points will be considered.

1. Hyperopia is the commonest cause because the focusing apparatus is at work all the time the eyes are open.

2. Myopia seldom, in itself, causes headache, because the eyes are at rest for distance and have less to do for near. Very low degrees may cause trouble, because the accommodation is constantly trying to clear up the blur, but without success. Headaches in myopes are more often due to accompanying muscle deviations.

3. Astigmatism. The oblique forms are especially important as objects are twisted; which is compensated by action of the oblique muscles to rotate the eye about its anteroposterior axis, or by head tilting, or by both. In certain cases of very high astigmatism, the optical disadvantages of such strong cylinders are so great that they cannot be worn. In some of these, operative measures on the cornea to reduce or neutralize the astigmatism are worth while. In one instance, I reduced a nine-diopter astigmatism to two by a thorough cautery of the cornea. The corrected vision improved from 20/100 to 20/30, and headaches stopped at once. This correction was maintained, at last examination, nine years after the operation.

4. Anisometropia is the condition in which the eyes differ so much in refraction that satisfactory binocular vision with the lenses is often impossible. Occasionally, as mentioned under the preceding heading, the difference may be reduced to bearable limits. Rarely we see what appears to be an impossible situation. One such in my experience was emmetropic in one eye, and 24 diopter myopia in the other, and for some reason had severe headaches. I extracted the lens from the myopic eye by needling, which reduced its refraction to 4D and again for some reason, the headaches stopped. Her corrected vision improved from 20/70 to 20/30.

5. Presbyopia at its onset is often accompanied by severe headaches because of the added difficulty of accommodation. This is due to the extra ciliary effort needed to make the necessary change in the focus of the lens.

B. Disturbances of the extra-ocular muscles. Leaving out of consideration cases of actual strabismus, which does *not* cause headache, and paralysis, we have the following conditions:

1. Esophoria, where the visual axes tend to converge and the corrective effort falls on the divergers. When of any amount the strain is severe because normally there is no need for those muscles to work except as rotators.

2. Exophoria, when the visual axes tend to diverge, calling for correction by the convergers. A greater degree of exophoria can be borne because the convergers can stand the strain of correction.

3. Cyclophoria, when the vertical axes tilt in or out. The correction must be made by the oblique muscles which often results in severe symptoms.

4. Hyperphoria, when one visual line is higher than the other. This condition causes symptoms out of all proportion because, in its correction, an entirely abnormal action of the vertical rotators must be made. Normally, both eyes look up or down equally; but here one must turn up while the other turns down, to bring both to the same level. I have seen instances of marked disability from one degree of disalignment. Luckily, prism corrections are borne better in moderate degrees. Vertical deviations often cause head-tilt in order to bring the eyes to a level and so save the ocular muscles. This tilt carries the shoulder down, which, in turn, means a spinal curvature. And all in a purely mechanical way. A complete eye examination in such conditions might be of great help to the orthopedist at times. Another common sign is an elevation of one eyebrow through an associated action of the frontalis in the effort to hold up the lower eye.

In the above-named conditions, the corrective strain is present as long as the eyes are open, even though not in use for near; which means that relief can be secured only by closing one or both eyes. The monocular occlusion test comes into play here in the diagnosis of the cause of symptoms.

5. Insufficiency of convergence when the visual axes cannot be converged close enough to permit continued use of the eyes for near. It has been proved that the eyes must converge easily to at

least four inches from centers to permit prolonged work at thirteen inches. In other words, two-thirds of the total power must be in reserve. In this connection the patient's occupation must be considered, for, even though he may have a normal test, he may have trouble if his work is done closer than thirteen inches. Frequently the muscle balance of these eyes is normal for distance, and in those the symptoms are related only to the near use of them.

C. Pupillary asthenopia is due to overwork of the pupilloconstrictor mechanism by excessive glare. At times it results from excessive artificial illumination when there is direct exposure. Photophobia occurring under ordinary conditions often disappears when errors in refraction and muscle balance are corrected. Therefore, tinted lenses are not in order, simply because the patient may complain of sensitiveness to light. The real cause must be searched for. Normally the pupils contract with accommodation and convergence. An undue contraction from glare may throw this associated action out of balance. Many office workers are sufferers from this trouble, and their stories of the refusal of employers to do anything to help are often almost unbelievable. In an Oakland laundry all the desk workers face the prevailing south sunlight; yet the proprietor has consistently refused to make a change because it would disturb the telephone wires ! !

* * *

III. HEADACHES OF NASAL ORIGIN

Joseph Goldstein, M.D. (945 Roosevelt Building, Los Angeles).—To the average layman any discomfort in the head is a headache. He recognizes only various intensities of the ache; if severe, he calls it pain. Constitutional diseases causing meningeal edema, ocular fatigue, pains from nasal origin, etc., all produce headaches.

Probably 50 per cent or more of all headaches in individuals under fifty years of age are the result of pathologic changes in the nose and accessory sinuses.

A brief description of the anatomy of the nose and these accessory sinuses, and their relationship to other structures of the head, is indicated. The two nares are separated by a firm septal partition. The lateral bony walls do not yield to ordinary pressure. The accessory sinuses empty into each naris through small ostia. The sinuses are normally separated from adjacent organs by bony walls. Some cells are found practically all around the orbit, in front and below the brain, and over the upper teeth. Any disease of one of these sinuses can produce pain and pathologic processes to any of the adjacent structures.

The mucosa of the nose contains mucus-secreting cells supported by loose areolar tissue. Such tissues swell readily if infected, or more often because of allergic manifestations. When any part or all the nose is filled by this hypertrophied tissue, producing pressure, we have headache or, if severe, pain.

Infections of the various sinuses produce, as a rule, typical pains. A frontal sinus headache comes on early in the morning and wears off during the day; and this is located just above the orbit. These patients frequently complain of asthenopia. Sphenoid disease usually produces pain in the lower half of the head, and is generally present in the afternoon. Ethmoidal disease is referred to the top of the head. Antral disease causes unilateral pain, and may be referred to the ear or behind the ear.

The most important ganglion of the nose is the sphenopalatine, lying just under the mucous membrane behind and above the posterior attachment of the middle turbinate. The posterior ethmoids and sphenoid, when diseased, frequently irritate this ganglion. Because of their many associating paths, pain and irritation are often referred to the eye, to the ear, or even down the neck, and into the shoulder.

Headache of nasal origin may follow (1) acute, (2) subacute, or (3) chronic pathologic processes within the nose and accessory sinuses.

1. *Acute.*—The common cold produces an acute edema of the mucous membrane, with secondary purulent drainage from the sinuses. Headache is the result of pressure of the engorged turbinates against unyielding structures, and by pressure of fluid in the sinuses, which cannot drain properly because of closed ostia.

2. *Subacute.* — Due to repeated or prolonged infections in noses which drain poorly, one or more sinuses may remain infected. This is frequently the result of a thick or badly deviated septum; or from hyperplastic or cystic turbinates. The mucosa of the sinus and the underlying tissue, including the basement membrane, are secondarily invaded by various microörganisms, usually streptococci, and we find, by antro-puncture, mucopus in the cavity. Headaches result from (*a*) absorption, (*b*) inflammation of the sphenopalatine ganglion, or (*c*) by extension to the surrounding organs.

3. *Chronic.*—Chronic nasal pathology, when not due to anomalies of the bony structures of the nose, are usually allergic. This is the leading cause of headache of nasal origin. The headaches are bizarre in type, frequently referred to the root of the nose, to the eyes, to the ears, the lower half of the head, or when once starting, then irritation of the sphenopalatine ganglion may have pain referred even into the neck and shoulder.

So far, our results in treating allergic diseases of the nose have not been altogether gratifying. There is still much to be done in this field. Frequently, changes in climate or environment are our only means of aiding the patient. At times, our allergists have been able to help them.

In conclusion, headaches of nasal origin are more common than suspected; caused by poorly draining sinuses and by pressure from within the nose against bony abutments and produced by acute, subacute, and chronic nasal pathology.

IV. DIAGNOSIS AND TREATMENT

Fred H. Kruse, M. D. (384 Post Street, San Francisco).—An adequate discussion of the diagnosis and treatment of headaches is a large subject. Volumes could be and have been written on classification, differentiation, and the suggested forms of treatment. Even when in agreement as to group names for different kinds of headaches, there is such a wide divergence of opinion as to specific causes in certain groups that therapy often becomes both conflicting and confusing.

The important thing is to recognize that any headache is a symptom, and even as a symptom does not too regularly fall into the usual symptom complexes or syndromes easy of recognition. Frequently the surface indications, as expressed by the patient, are misleading, and the real story has to be patiently elicited. In fact, headaches as a group have the embarrassing distinction of all appearing very much alike on the surface; and frequently it is only by the most careful analysis of the anamnesis that they can be fitted into a distinguishable category.

It is true that the migrainous, neurotic and asthenic types, the circulatory and increased intracranial pressure group, as well as the toxic and infectious groups, present common characteristics often readily recognizable. However, there are a host of disturbances simulating any or all of these, and even queer variations within certain groups, especially in their inception, which may lead us astray from the real underlying etiologic factors.

Often the practitioner, occupied with many disorders, is too busy at the time for thorough investigation. It is easier to prescribe a sedative. The patient with frequently recurring headaches then moves on in his search for someone who will determine the cause of his trouble. For the more recent headaches with acute onsets, a quick survey, including an inspection of nose and throat, temperature, blood count and blood pressure, is sufficient to determine whether a hypertension, an acute sinus, respiratory infection, or other infectious disease is present, or if the trouble is of sudden nervous origin. It is with the persistent headache and the more chronic recurring types that we have our troubles.

These patients should be brought back for a careful study. Both Barber and Robey, in discussing such cases, lay great stress upon a careful medical history. Unless we can immediately demonstrate a brain tumor, a hypertension, a sinus with bad drainage, or an infectious disease, our search will probably take us far afield into family history, home environment, living and dietary habits, allergic disturbances, endocrine dyscrasias and complicated digestive, metabolic and food disorders. It is better to try to get all the story at once, instead of piecemeal on occasional visits. It is also well to listen to and record carefully the spontaneous statements of the patient, and then, by skillful questioning, ascertain the character, frequency, duration, intensity, site and radiation of the ache or pain in the head. This should be amplified by finding out how and when the headaches first began and of their progress and change since.

Heredity is important especially in relation to such diseases as syphilis, hypertension and migraine, and hence a careful family history must be taken. The past history and review of previous diseases and environmental situations are important. Finally, we must not forget how difficult it is for many people accurately to describe what they feel or have felt. Many people fail to discriminate among their sensations, and it is only by careful inquiry that we can determine whether they have a violent pain, a dull ache, a feeling like a tight band about the head, or cap or hat pressure in the head. Location as to vertex, frontal region, occiput, or neck and back of the head pain, with radiation and drawing of the upper back muscles, is necessary for diagnosis.

As for the rest of the examination, I know of no more admirable summary than that of Lewellyn F. Barker given before a clinic to physicians in 1928:

"Important as is the analysis of the patient's subjective complaints, the objective examination of the patient suffering from headache, is no less momentous. This objective study should be pushed far enough to differentiate among the various possible causes of the headache. It should, of course, include a careful general physical examination, during which the blood pressure should be determined and the eye grounds examined. In how far laboratory tests, x-ray tests, and examinations by specialists shall be applied in a given case must be left to the training, experience and common sense of the examiner. Superfluous tests should be avoided; indispensable tests should never be omitted."

The following group will include practically all kinds of headache, and is of convenience in considering diagnosis and treatment:

1. Headaches of infectious origin.
2. Headaches of toxic origin.
3. Headaches of cardiovascular renal disease.
4. Headaches due to disorders of special senses: eye, nose, etc.
5. Headaches due to organic diseases of brain and skull and other head structures.
6. Migraine.
7. Headaches due to functional disturbances of the nervous and digestive systems.
8. Endocrine headaches.

Of the above, the infectious migraine, and the various functional disorders of the nervous and digestive systems, often with an associated asthenia, and undernutrition, will constitute at least 90 per cent of all the headaches with which the general physician has to deal.

1. *Headaches of Infectious Origin.*

Almost any infectious disease and many focal infections will produce headache. The history, clinical findings, presence of fever and variations from normal in the blood count will determine whether home supervision or hospitalization, with other laboratory investigation such as blood cultures, agglutination tests, lumbar puncture, x-rays, etc., will be necessary The enteric fevers, men-

ingitis, poliomyelitis, trachiniasis, influenza, epidemic encephalitis, malaria, pneumonias and acute sinus infection, cause the most severe and often, at first, the most baffling types. The treatment, of course, is symptomatic and that of the disease itself.

Syphilis is a frequent cause of headache. The importance of the recognition of the headache of syphilis on account of the advantage of prompt treatment, which may save the patient from paralysis and mental breakdown, cannot be overestimated. Intensity, persistence and nocturnal exacerbations characterize the headache. The pain has been likened to a weight on the head, sometimes to compression of the head in a vise, and at other times to blows on the head with a hammer.

I had a patient recently with syphilis who talked of throbbing and pounding in her head. It was especially bad at night, and a phonograph in a neighboring apartment would seem to start and exacerbate the beating. The intensity and long duration of the headaches are of great importance in diagnosis. Attacks sometimes occur for several years before the supervention of further cerebral trouble. Periostitis and nerve pressure may give rise to headache in syphilis, also meningitis and syphilitic arteritis, which are more apt to cause the typical headache described above. In meningitis and syphilitic arteritis, the headache is diffuse, intense, persistent, and worse at night. In the secondary stage of the disease, the headache may be in active association with the eruption. It is apt to be occipital, and to increase in intensity toward night. It may go over the entire head, or it may be limited to one side of the occiput. Periosteal swellings are found chiefly on the frontal and parietal bones, and there is not only a lot of head pain, but great sensitiveness to pressure.

It would, therefore, seem important always to have a Wassermann taken in studying headaches, and if there is any evidence of any central nervous system disorder, of course, a lumbar puncture should be taken. These headaches yield gradually, but finally dramatically, to the proper anti-luetic treatment.

Nodular (rheumatic) or indurative headache is very chronic. It begins in the occiput and nape of the neck, may involve the entire head, keeps on at night, and is often worse in the recumbent position. Careful palpation discloses nodules, the size of a millet seed to that of a bean, in the subcutaneous tissue of the scalp and neck. They are very sensitive to touch, due to inclusion of sensory fibers of the fifth and occipital nerves. Local massage and heat, clearing of focal infections, iodids and analgesics, are the measures of election for relief.

2. *Headaches of Toxic Origin.*

Of the toxic causes of headaches the abuse of alcohol and tobacco, carbon monoxid poisoning (especially the chronic form); methyl alcohol; anilin poisoning; therapeutic use of nitroglycerin and amylnitrate, and occasionally iron and bismuth subnitrate are the most common. Some individuals are hypersensitive even to moderate use of alcohol and tobacco, and merely sitting in a room filled with cigar smoke may cause them to have night or morning headaches. I have seen a low-grade, dull headache cease when the administration of iron by mouth for anemia was stopped. So-called intestinal toxemias with headache will be discussed with the functional headaches.

3. *Headaches in the Cardiovascular-Renal Disease Groups.*

These are frequent. Headaches occur in vascular hypertension, in chronic nephritis, and in chronic nephritis with hypertension. The headache is often of the same type and is fairly characteristic. It is an excruciating, dull headache, intermittent or continuous in character affecting, as a rule, the whole head, but centering in the occiput. As a rule it is occipital, and is worse in the early morning. It wears away during the day as the circulation increases with activity. It often awakens the patient in the early hours. Generally the blood pressure is high, although it may be relatively low. The ophthalmoscope discloses the usual vascular or renal retinal changes, and studies of the urine, blood chemistry, and kidney function afford the differentiation as to the type of disease present. The treatment is that of the disease determined. Usually the diet should be restricted, consisting mainly of milk, carbohydrates, vegetables, and fruit. The protein and salt intake should be determined by the blood-chemistry findings. Elimination by the bowels, kidneys, and skin should be promoted. The strength of the heart should be maintained.

In crises of hypertension, bleeding (generally 200 to 300 cubic centimeters of blood) may be helpful. Lumbar puncture may be of advantage at times to relieve headaches. The use of pyramidon, salicylates, codein, sedatives, and hypnotics should be carefully supervised and restricted, but some may be necessary. Bed rest is of the greatest importance.

While gout does not belong in this group, "gouty headaches" may be mentioned here, since there is often an associated arteriosclerosis in gout. Unexplained headaches in arthritic or other patients with tophi or joint symptoms should lead to a study of the purin metabolism. In polycythemia, headache may be the most common subjective symptom. Headache may be the chief symptom in the onset of acute nephritis, in which case urinary examination will be the principal diagnostic aid.

4. *Headaches Due to Disorders of Special Senses.*

See previous discussions for these.

5. *Headaches Due to Organic Diseases of the Brain.*

These will not be discussed here.

6. *Migraine.*

Migraine (bilious, sick, or periodic headaches) is inherited as a dominant unit Mendelian character. The part heredity plays is to produce a sensitized nervous system. The periodicity of attacks, the comparative well-being between them: the frequent association in women with menstruation;

the peculiar eye sensations of blurred or partial vision and scotomata; the headache which is deep in the skull, frequently hemicranial, but radiating variously to the temple, nose, and to the back of the neck, spreading all over the head; the frequent association of nausea and vomiting, and the less frequent attacks of true abdominal migraine, consisting usually of a severe cutting or boring epigastralgia, which is independent of and uninfluenced by food, and which may radiate (although it is generally limited to the epigastrium), are the chief characteristics. Even in the presence of organic pathology found on physical examination, this history should make any physician exceedingly wary of resorting to any surgical aids for treatment. These individuals are high strung, nervous, generally underpar physically, and present many other complaints. Careful analysis of their histories may indicate the need of attention to eyes, nose; functional regulation of the intestinal tract; supplying glandular needs (see below); restoring nutrition; changing environment and type of work, and perhaps, as suggested by Tom Brown, restricting either the use of carbohydrates, or proteins, or studying food allergy, as suggested by Rowe. I have beeen disappointed in the efficacy of any one specific form of treatment, however, and have found the general fundamental régime as described above, including the administration of calcium and mild sedatives, the most helpful. The headaches finally disappear.

7. *Functional Headaches.*

The headaches of functional disorder, exclusive of migraine, may vary from the dull, heavy frontal type, with a feeling of head fullness and congestion, frequently with stuffy nose and related abdominal discomfort, with colon fermentation, carbohydrate intolerance, and spastic constipation; alternating with splattery, gassy stools, to the purely neurotic type, where the headache is more a sense of pressure, diffuse in character and covers the entire skull cap, with a feeling of constriction like a band about the head. Often in these latter cases there is considerable loss of weight, undernutrition; ptosis and general nervous exhaustion, as well as reflex digestive symptoms. Such symptoms are often relieved by bed rest. The cure in the first group is obviously dietary and correction of the colon disorder; of the second, restoration of nutrition, rest, relaxation, and general reconstruction of the physical state alone will bring any improvement.

8. *Endocrine Headaches.*

Some women, who have been subject to migraine in early life, are very likely to suffer from headache of the menopause. The pain is dull, often frontal, but the vertex may be a prominent site. It may be constant, day and night, but usually occurs two or three times a week. It is aggravated by physical and nervous strain. Besides menopausal symptoms, there may be a mild myxedema, and a minus basal metabolic rate. Small doses of thyroid as well as ovarian substitution therapy afford great relief.

Pituitary headache may be associated with tumor or dysfunction. Distention of the pituitary capsule, aside from tumor, as in the case of a very small sella, closed in by the clinoids, may produce periodic headaches of obscure origin. Some of these lack the visual symptoms of classical migraine, and occur particularly at menstruation. We know that menstrual bleeding depends on the activity of the anterior pituitary. The headaches are usually bitemporal, frequently severe and persistent. Pituitary feeding has relieved some of these, and A. P. Thomson reports improvement of the headaches following administration of the ovarian follicular hormone which, in animals, has been shown to reduce the size of the pituitary body.

Exophthalmic goiter may give rise to migrainoid headaches.

American Medical Association Officers by States.—The May, 1934, *Journal of the Indiana State Medical Association* gives a tabulation of officers and committees of the American Medical Association over a ten-year period. It states:

Recently there has been some comment concerning the matter of state representation in the American Medical Association, and for that reason the present study was undertaken, covering a period of ten years. The results are shown in the following table:

Alabama	11	Missouri	16
Arizona	0	Montana	0
Arkansas	0	Nebraska	9
California	14	Nevada	0
Colorado	14	New Hampshire	0
Connecticut	71	New Jersey	1
Deleware	0	New Mexico	0
District of Columbia	39	New York	65
Florida	0	North Carolina	0
Georgia	11	North Dakota	0
Idaho	0	Ohio	51
Illinois	212	Oklahoma	0
Indiana	13	Oregon	13
Iowa	8	Pennsylvania	30
Kansas	8	Rhode Island	0
Kentucky	2	South Carolina	0
Louisiana	13	South Dakota	0
Maine	0	Tennessee	10
Maryland	21	Texas	8
Massachusetts	49	Utah	0
Michigan	34	Vermont	0
Minnesota	36	Virginia	7
Mississippi	0	Washington	1

Salicylates in Rheumatic Relapses.—Perry treated forty-one children suffering from rheumatic heart disease with acetylsalicylic acid. The dose was 10 grains (0.65 gram) three times a day for twelve months. The patients were seen every three or four weeks and observations were made on their symptoms, physical signs, and weight. The authors observed that the body weight is a valuable guide to the progress of these cases. Relapses of a rheumatic nature, *i. e.*, chorea, arthritis or carditis, were observed in 12.1 per cent of the treated patients as compared with 17.9 per cent of the 106 controls. The abnormal physical signs in the heart decreased or disappeared in 34 per cent of the treated cases as compared with 24.5 per cent of the controls. Of the treated cases, 12.1 per cent showed an increase in the physical signs as compared with 8.4 per cent of the controls. For all ages the average gain in weight showed no significant difference in the two groups. In regard to general health, the parents of some of the patients stated that there was an improvement, while others stated that the children were no better.—*Lancet.*

"The county nurse who works well and thinks intelligently is sure to do much more than affect the limited area in which her work lies, for she is blazing a trail that will in time become a broad highway."—Gardner.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this journal.

Leaflet Regarding Rules of Publication.— California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

POSTGRADUATE SERVICE—C. M. A. EXTENSION LECTURES AND CLINICS

The Work of the California Medical Association Committee on Extension Lectures.—When, on May 8, 1929, at the annual session in San Diego, the California Medical Association adopted its present constitution and by-laws, it provided for a standing "Committee on Extension Lectures"; which committee, at the present time, consists of Doctors James F. Churchill of San Diego, J. Homer Woolsey of Woodland, Robert T. Legge of Berkeley (chairman), and, ex officio, the Association Secretary. This committee made a report, addressed to the members of the component county societies, and printed on page 45 of the January number of CALIFORNIA AND WESTERN MEDICINE, to which attention is once again called, both because of the importance of the subject and the desirability of county society coöperation. Every such unit might well have a standing committee on postgraduate study, whose function would be to aid in bringing the efforts of the State Central Committee to happy fruition.

Chairman Legge and the Association Secretary, who are, naturally, at the members' service and will welcome any helpful suggestions, are particularly anxious to render all possible aid in supplying speakers to talk and demonstrate on topics of general or local interest. This year's plans of the California Medical Association Committee on Extension Lectures contemplate something more than merely printing, as heretofore, a list of lecturers, from which the program committees of component societies could choose an occasional "extra-county" speaker for a monthly program. It is hoped to change so haphazard a method and to bring about real interest in postgraduate studies throughout the entire State by not only having lists of speakers, but by assigning them to as many communities as possible for one- and two-day postgraduate sessions.

* * *

Every County Medical Society Should Coöperate.—It is designed that the president and secretary of each county society, acting with the local committee, if such exists, should submit a report at the next monthly meeting, and then communicate with the Association Secretary so that the proposed extension work may be started. The interesting item on postgraduate study (printed on page 43 of the January issue) might well be read at each county society meeting, because it not only explains the need of supplementary study and research for almost everybody, but makes clearer why, through lack of such study, many licensed practitioners fail to become affiliated with medical organizations. Postgraduate application is very necessary since it makes not only for individual improvement, but for development of a stronger and better expression of scientific and organized medicine.

Because the committee, of which Doctor Legge is chairman, is anxious to serve the Association everywhere, it is to be hoped that county society officers and members will give whole-hearted and early coöperation.

THE LEGISLATURE IS IN SESSION

Report on Proposed Public Health Legislation Not Yet at Hand.—The California Legislature is in session, but at the time of this writing the legislative hopper is still comparatively empty. Before January 26, however, when the January-February recess may be expected to commence, unless this year's legislature is different from its predecessors (which it most likely is not), a complete assortment of prospective laws will have been placed on file. In due time, thereafter, the California Medical Association's officers will bring to the attention of county societies those measures having a bearing on public health and medical matters.

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

What California Medical Association Members Can Do During the Constitutional Recess.—During this period of thirty days (from January 26 to February 26), devoted to a constitutional recess of one month, many State Senators and State Assemblymen will be in residence in their home communities, and attention is called to the December issue, page 431, where will be found a complete roster, with home residential directory, of the present fifty-first California Legislature. Why not, therefore, get the names of your Senator and Assemblyman and make an effort to meet and establish cordial relationships with them? You are one of their constituents, and because of your profession and influence, each will have every reason to be happy to meet you. You may wish later on to communicate with them formally, and such prior personal acquaintance would add to the value of any letter you might send them. There is little legitimate reason for the passage of obnoxious public health legislation, and much of such would die in committee in both Senate and Assembly were the makers of the laws but better informed on the need thereof—and thus our legislators might well be, if physicians would maintain those familiar and confidential relationships with both Senate and Assembly members, to which so generous and altruistic a profession as that of medicine is entitled. Avail yourself, therefore, in the recess month of February of the opportunity to meet the legislative representatives in whose districts you vote.

C. M. A. HOUSE OF DELEGATES, IN SPECIAL SESSION, TO HEAR THE REPORT OF THE COMMITTEE OF FIVE

Action of the Riverside Annual Session.—At last year's annual session of the California Medical Association at Riverside, the subject of health insurance was the major topic of discussion in the House of Delegates; and the seriousness with which the theme was considered is evident in the action taken, that a special survey committee be appointed with authority to spend of the Association's funds, such sums as the committee, the Council concurring, deemed necessary to carry its work to proper conclusion.

Since then every member of the California Medical Association has received questionnaire blanks calling attention to what the Committee of Five is trying to do, in the collecting of accurate and comprehensive facts and figures on the incidence of sickness in California, and its related social welfare and economic features. In addition to procuring the information expected from physicians, it has been possible, through coöperation with the California State Board of Health, to institute a field survey covering twenty-five counties; this work, secured through federal aid, being done at a cost of more than $60,000.

* * *

The Work of the Committee of Five.—The Committee of Five (consisting of Doctors Molony, Peers, Kilgore, Yoell, and Wilson), which has been in charge of this important work, has kept to itself its tentative findings; the Council of the Association authorizing funds when needed, while brief reports on general progress were made.

That the collecting of factual information, such as is being gathered by the California Medical Association, is no easy task, is attested by the several years found necessary for the national Committee on the Costs of Medical Care (of which President Ray Lyman Wilbur of Stanford was chairman) to assemble the data collected for its voluminous reports. The California Medical Association's Committee of Five has been imbued with the seriousness of its responsibilities to both the people and the medical profession of the State; but while it has been making all possible effort to expedite the gathering of the information desired so that economic and other experts could compile and make deductions therefrom, it has been firm in its intention not to expend money wastefully, through haste, that would lead only to possible inaccuracies such as might invalidate the data and findings. In taking this stand we believe the Committee of Five has the cordial and almost unanimous approval of the members of the California Medical Association.

* * *

Special Session of the House of Delegates at Los Angeles on March 2.—These lines are written at a time when the general officers and councilors of the Association know no more of what will be in the report of the Committee of Five than do the members at large. Nor has any attempt been made to find out beforehand what trend the investigations are taking or what will be the conclusions or recommendations brought in to either the Council or the House of Delegates. There is every reason to believe, however, that the money disbursed has been wisely expended and that the factual information that now is being gathered will prove of great value not only to California, but to other states in the Union; and on that account the final report is awaited with keen interest.

* * *

Since writing the above, a progress report has been made to the Council (at the meeting of January 19); and after hearing the same the Council voted to call an extra session of the House of Delegates for a meeting to be held at Los Angeles on Saturday, March 2, at which time definite reports and recommendations will be submitted.*

*See page 126 for the official call to the special session of the House of Delegates.

Both modern public health and modern medicine grew out of the earlier chaos slowly and painfully indeed, developing in consonance with the development of the sciences fundamental to biology—anatomy, physiology, physics, chemistry. Just as these sciences relate to each other, yet have each also huge areas in which they seem wholly distinct, so public health and medicine correlate in many points, mutually support and aid each other, yet have huge fields each of their own.—H. W. Hill, M. D.

EDITORIAL COMMENT*

CONFUSION OF PARTIAL HEART-BLOCK WITH EXTRASYSTOLES

Premature ventricular contractions, so-called extrasystoles, are frequently of little significance as to prognosis or treatment, particularly when they occur in young individuals. Heart-block of any degree, however, and at any age, is more significant, and indicates a definite myocardial lesion except in those cases of short duration due to toxemia or similar noxious influences. The former very frequently, if not in most cases, requires no treatment and may even be neglected without any resultant harm; the latter demands caution in prognosis and treatment always, not necessarily medical, however, as rest in bed may be sufficient in a mild case, especially when of a toxic nature.

There are many individuals, usually in or about the second decade of life, who present the appearance and history of what commonly passes under the name of neurocirculatory asthenia, or more colloquially "nervous heart" or "irritable heart." They very frequently show extrasystoles on auscultation, or what seem to be extrasystoles. These extra beats are diagnosed according to the general appearance of the case, and dismissed with a prescription for bromides or I. Q. and S.

Lutembacher, in a recent number of *La Presse Médicale*,[1] cites a case of this nature in which the electrocardiogram showed the apparent extrasystoles to be really due to a two to one heart-block. To quote him: "It concerns a young girl of thirty years. She complained of sudden attacks of malaise and dizziness. The blood pressure was normal; an irregularity in cardiac rhythm was considered to be extrasystoles due to reflex phenomena of digestive origin. For many months the patient submitted to the most varied regimens and took many medicines, without result.

"As the cardiac disturbance progressed, digitalis was proposed. However, with the prolonged administration of this medicine, grave symptoms appeared suddenly, such as attacks of syncope with epileptiform accompaniment. The cardiac rate was considerably decreased. These attacks continued for more than eight days, when they began to decrease in proportion to the elimination of the digitalis from the body.

"In spite of this warning, nothing was done to determine the precise nature of the arrhythmia. Months passed. The patient experienced a syncopal attack in the street. . . . Then an electrocardiogram was taken. It revealed an incomplete block, and explained all the phenomena observed, the malaise, the dizziness and the sudden aggravation of the trouble under the influence of digitalis. . . .

"In this case there was no sign of cardiac insufficiency authorizing the use of digitalis; the heart was not enlarged and there was neither dyspnea nor signs of stasis."

The history of this case revealed nothing in the patient's past or family that would give a clue to the etiology, but as the patient had had three miscarriages mercury was administered, in spite of a negative Wassermann, and the symptoms disappeared; the block disappearing entirely after six months of treatment.

As Lutembacher says, "For a long time, precious time was lost and the patient exposed to the danger of a sudden death. The study of ventricular rhythms . . . is not a vain, theoretical speculation; it leads to practical deductions of the greatest interest."

746 Francisco Street.

Louis Baltimore,
Los Angeles.

GROUND BONE AS FOOD AND MEDICINE

During the past twenty-five years it has been my good fortune to observe the effects of the administration of fresh and dried bone, mechanically reduced to a suitable size for administration to humans, both as a food and a medicine. Experiments on dogs and cats demonstrate the necessity of bone as a part of the diet of all flesh-eating animals, to maintain a normal condition of health; and as man, especially the Anglo-Saxon and we modern polyracial Americans, are liberal consumers of the flesh of animals, birds, fish and other animal foods, the necessity for a certain amount of calcium (bone) to help balance our diets and maintain a normal calcium balance, is obvious. We find a large proportion of children, and not a few adults, suffering from a calcium deficiency, although seemingly fed on a well-balanced diet of protein, carbohydrate, hydrocarbon, water, etc., in proper proportions. All carnivorous animals, as above stated, require raw bone in their diets. Even the baby walrus in the San Diego Zoo had to be fed on a diet of shellfish, principally clams with the shells crushed, to keep down excessive stomach acidity and prevent him from having pain and colic as soon as his milk-feeding days were over. How to feed bone to humans became a problem. We moderns cannot gnaw bones, as did our primitive and, later, semi-wild ancestors, and we might balk at using scraped deer horn, as the Chinese have done for several thousand years. With the Chinese this form of calcium is a great medicine. Cooked bone being worthless, newly scraped bone was used. Each day a piece of fresh, clean bone was rasped or scraped until about a teaspoonful was obtained. This was fed in mush, puddings, jelly or some protective covering, to insure ease in swallowing.

Today there are on the market several preparations of ground beef bone, which have been treated in vacuum pans, and is a very good substitute for the fresh bone. It does the work, is easy of administration, but is not quite as effective as the freshly prepared article.

* This department of California and Western Medicine presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Lutembacher, R.: La Presse Médicale, Vol. 42, No. 5 (Jan. 17), 1934.

Uses: Any child or adult who is suffering a calcium deficiency, no matter what the physical symptoms or pathology may be, can be normalized and restored to a healthy balance by the daily administration of ground bone. The dose is not limited, for the gastric juices can only take care of sufficient to bring about a normal calcium balance, and any excess will be passed on as harmless residue with the other undigested elements of the food.

In malnutrition, rickets and other faulty bone development, delayed dentition and skin diseases which are due to nutritional disorders, a daily dose of ground bone will work a marked change when combined with other necessary hygienic and dietetic measures. Appetite and digestion are improved, body building, bone and muscular development are augmented, and they seem to take on new life.

The writer has several boys and girls under observation who have had a small daily dose of ground bone ever since they were one year old, the oldest being eight years; all are physically perfect, without carious teeth—in fact, have perfect dentures—and all are unusually free from infectious and epidemic diseases.

In tubercular diseases, especially of the lungs, ground bone, in teaspoon doses along with other appropriate measures, hastens the arrest of the malady and the early calcification of the tuberculous area. All my tuberculous patients receive raw, scraped or chopped meat, raw fertile eggs and two daily doses of ground bone, in addition to other accepted methods of treatment.

In gastric ulcer a very finely powdered bone is a perfect antacid, and can be given freely to effect, to counterbalance excessive acidity; and together with proper diet will help heal those annoying ulcers. Ulcers and infections of other parts of the body can be helped by the administration of ground bone, since in all such cases a calcium deficiency usually exists.

To my mind, after years of experiment and observation, there can be no question that we humans, feeding as we do, should partake of a portion of fresh ground bone to help maintain our body calcium balance, as do the carnivorous animals who follow the law of nature by eating not only the flesh of their prey, but some of the bone, glands and, at times, the viscera as well.

533 Mendocino Avenue.

W. C. Shipley,
Santa Rosa.

DIET IN UROLOGY

The rôle of diet in the treatment of genito-urinary diseases is receiving increasingly greater prominence. Some of the older dietary principles, such as the forcing of fluids in infections, laxative diets and avoidance of foods irritating to the urinary mucosa, still hold a prominent place in the urologist's treatment armamentarium. The proper type of forced feeding is frequently of value for the debilitated prostatic; or a blood-building dietary will often go far toward preparing the patient with a malignancy for surgery.

In patients who have a tendency to develop uric acid calculi, a purin-free diet is indicated. Alkalinization, or acidification of the urine, is often desirable, the former in infections, especially the cocci group, or in patients with oxalate stones, and the latter in those with a bacillary infection or infections having phosphatic stones. These changes in reaction of the urine can often be brought about or aided by the proper diet.

Recent investigations have added still more to this field. Helmholtz found that a ketogenic diet consisting of 80 per cent fat will often sterilize the urine to such an extent that a urinary infection is eradicated. Bliss, Livermore, Prather, and others, have demonstrated that a diet deficient in vitamin A will produce urinary calculi in rats.

When considering the importance of both the old, accepted dietary principles, and the more recent developments in this field, it is evident that diet does have a very definite place in the treatment of genito-urinary diseases, and should be used more extensively.

707 Medico-Dental Building.

Roger W. Barnes,
Los Angeles.

Action of Milk Injections in Gonococcic Infections.—The therapeutic efficacy of milk injections in gonorrhea, and particularly in the metastatic eye disorders, induced Buschke and Casper to study the action mechanism of milk injections in animal experiments. Studies on white rats disclosed that prophylactic intraperitoneal injections of milk protect the majority of the animals against a gonococcic infection induced with ten times the lethal dose. This could perhaps be interpreted as indicating an active immunity conferred on the animals by the milk injections. However, the authors point out that milk therapy has no influence on urethral gonorrhea, while it is highly effective in gonorrheal conjunctivitis, and that specific gonococcus vaccines do not influence the metastatic eye diseases of gonorrhea. Thus the action of milk cannot be considered due to the production of a specific immunity. The authors assume that the gonococcus produces certain toxins and that the milk checks the formation of toxin in the organism. By influencing the reticulo-endothelial system, it stimulates the leukocytes to phagocytosis and to the formation of protective substances.—*Klinische Wochenschrift.*

Cats and Scientists Give Verdict of "Wholesome" on Toledo Relief Meat.—Sixteen healthy cats, several laboratory food specialists, and a number of trained meat inspectors, including a specialist on canned meats, have returned a verdict of "wholesome" in favor of the relief meat distributed in Toledo, Ohio, and vicinity, where suspicion was recently aroused because of a number of cases of illness among children. The cats took an important part in checking up the evidence because they are dainty eaters and have been found the most effective test animals in food cases of this type. Local authorities had used mice in making preliminary tests and on the basis of their results had issued a statement that the meat was bad. Mice, say the Federal authorities, are not as dependable as cats for testing meat. Cats usually refuse even slightly spoiled meat, but if they do eat bad meat their reactions are immediate and unmistakable. . . .—United States Department of Agriculture Press Service.

CALIFORNIA MEDICAL ASSOCIATION

FREDERICK C. WARNSHUIS, M. D., Associate Editor for California

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

CLARENCE G. TOLAND.....President
ROBERT A. PEERS.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

OFFICIAL NOTICES

Special Meeting of the House of Delegates.—The following is the official call for a special meeting of the House of Delegates:

OFFICIAL CALL FOR SPECIAL MEETING OF THE HOUSE OF DELEGATES OF THE CALIFORNIA MEDICAL ASSOCIATION

To Officers, Delegates, and Members of the California Medical Association, Greetings:

The Council of the California Medical Association hereby issues and gives official notice of a call for a special meeting of the House of Delegates of the California Medical Association, in the following resolution adopted by the Council at its meeting on January 19, 1935:

WHEREAS, Pending and proposed Federal and State legislation related to medical care and medical services makes it imperative for the California Medical Association to formulate principles and policies that will declare its position in regard to such legislation; therefore be it

Resolved, That the Council of the California Medical Association, under provisions stated in Article IX, Section 5, of the Constitution, direct the Association Secretary to issue a call for a special meeting of the House of Delegates to convene at 1 p. m. on the second day of March, 1935, in the city of Los Angeles at the Los Angeles County Medical Association building, 1925 Wilshire Boulevard; and be it

Resolved, That the object of such special meeting shall be:

(*a*) To receive and consider the report of the Committee of Five and to take such action thereon and to formulate such principles and policies in regard to health insurance, medical services and medical care as the judgment and wisdom of the delegates may determine to be for the best interests of the public and the members of the Association.

(*b*) To transact such other business of the Association as may be transmitted to the House of Delegates by the Council of the Association; and be it

Resolved, That the order of business shall be as follows:

1. Call to Order.
2. Report of Credentials Committee.
3. Roll Call of Delegates.
4. Reading of the Call.
5. Report of the Committee of Five.
6. Resolutions.
7. Council Communications.
8. Report of Reference Committee.
9. Adjournment.

(Signed) T. HENSHAW KELLY, *Chairman.*
E. M. PALLETTE, *Speaker.*
C. G. TOLAND, *President.*

Attest: Issued January 29, 1935.
San Francisco, California.
F. C. WARNSHUIS, *Secretary.*

This call and instructions pertaining to credentials and selection of delegates have been sent to every delegate elected for the 1934 meeting of the House of Delegates and to every county secretary. To be seated, delegates must secure credentials from their county secretary and present their credentials to the Credentials Committee on February 16, 1935.

* * *

To the Members of the House of Delegates of the American Medical Association.—In compliance with the official request of the Board of Trustees that the House of Delegates be convened in special session, I as Speaker, under authority of Chapter III, Section 2, of the By-Laws, hereby officially call the House of Delegates of the American Medical Association to convene in special session in the city of Chicago, State of Illinois, at 10 a. m., central standard time, on the fifteenth day of February, 1935.

The business to be transacted at this special session shall be limited to the consideration of the social and economic policies of the Association as related to pending and proposed legislation, to sickness insurance and to other matters which may be submitted by the Board of Trustees.

The House shall remain in session, recessing from day to day, until its deliberations are concluded.

Signed and issued in San Francisco, California, January 21, 1935.

FREDERICK C. WARNSHUIS, M. D.,
Speaker, House of Delegates, American Medical Association.

* * *

Make Annual Session Reservations Now.—There is every indication that there will be a splendid attendance when the California Medical Association meets in Yosemite Valley, May 13 to 16. Already there is a waiting list for reservations at the Ahwahnee, which will be the convention headquarters. Reservations being confirmed currently are being made at Camp Curry and at Yosemite Lodge.

Since accommodations at the Ahwahnee could take care of only two hundred persons, it was understood that the larger number of delegates and wives would stop at Camp Curry, where some of the meetings, including the general sessions, will be held, and at Yosemite Lodge. Camp Curry is a ten-minute walk or about a three-quarter-mile drive from the Ahwahnee, and Yosemite Lodge is about one mile west. Both places have comfortable accommodations with bath. Camp Curry has detached, two-bedroom bungalows with either tub or shower baths; redwood cabins and tent-cabins without bath. The bath cabins at Yosemite Lodge are comparable to the Camp Curry accommodations. All bath cabins are heated electrically. Write for your reservations today.

MONTH'S ACTIVITIES

Council.—The regular January meeting of the Council was held in San Francisco on January 19. In addition to routine business, special consideration was given to the report of the Committee of Five, legislative proposals and a special meeting of the House of Delegates. On January 20 a special committee of the Council conferred with the Senate's Interim Com-

mittee in Sacramento. The Executive Committee of the Council, the trustees of the Association, the Committee on Public Relations, convened in the Association's offices on January 18. Official minutes of these meetings will appear in the March issue. This issue contains the minutes of the December Council meeting. The Council will hold a special meeting in Los Angeles at 10 a. m. on March 2, 1935, before the special meeting of the House of Delegates.

The Association's Special Committee on Practice of Radiology and Pathology in Hospitals met with a committee representing the California hospitals of the Western Hospital Association on January 17. Another meeting will be held February 2, when it is anticipated that an agreement will be reached upon regulations governing these hospital departments.

* * *

Council Meetings.—The Council met on December 22 and 23 and January 19 and 20. See minutes in last month's and this month's issue.

* * *

Scientific Program Committee.—The Scientific Program Committee met on January 27 and adopted a program for the annual session, May 13 to 16.

* * *

County Meetings.—The Secretary attended the following county meetings: Sacramento and Alameda counties, and on January 16 addressed the San Francisco Y. W. C. A.

* * *

SERA State Plan for Medical Care.—As this issue goes to press there is an impasse because of the vacancy in the office of State Administrator. There is no one in authority to approve the proposed state-wide plan of medical care. An appeal has again been made to Washington. Your Association's Advisory Committee is persistently pursuing its insistence that a State plan for providing medical care must be inaugurated.

* * *

Eastern Meetings.—The annual conference of the Council on Medical Education and Hospitals and State Licensing Boards will be held under the auspices of the American Medical Association in the Palmer House, Chicago, on February 18 and 19. The American Medical Association trustees meet on February 20 and 21.

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Federal Health Program.—On January 7, United States Senator Black introduced the following resolution that apparently indicates that the Federal Government is without sufficient information upon which to draft a health insurance law: *S. R.* 28:

Resolved, That the Committee on Education and Labor of the Senate is hereby directed and instructed either acting through the full committee or through a duly appointed subcommittee, as soon as practicable, to make full and complete investigation in order to determine the best and most effective kind of federal legislation to provide a system of health insurance throughout the entire United States and to report to the Senate as early as practicable the recommendations outlining the kind of legislation it is believed will most effectively accomplish this purpose."

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Advertisers.—The Coöperative Medical Advertising Bureau of Chicago urges, in a letter dated January 9, that county secretaries request their members to answer and patronize State JOURNAL advertisers. Such coöperation is solicited. Unless advertisers receive reasonable returns upon their copy their contracts for space will be discontinued and the JOURNAL will suffer from loss of income. The Council appeals to all members to respond by contacting our advertisers.

Legislation.—Legislative developments will be transmitted as they arise to county officers. These communications should be accorded prompt attention and action.

* * *

Special Meeting of the House of Delegates of the American Medical Association.—On January 21 a call was issued for a special meeting of the House of Delegates of the American Medical Association in Chicago on February 15 and 16, the purpose being to consider pending and proposed federal and state health insurance legislation.

California will be represented by its seven delegates. It is hoped that the deliberations and the actions recorded at this special meeting will be of helpful value in solving related problems in California.

STATE AND COUNTY SOCIETY ACTIVITIES

EDUCATION IN YOUR RECEPTION ROOM

An awakening on the part of physicians as to their responsibility for educating the public in regard to the truths of scientific medicine, its resources for the prolongation of life and the prevention of disease is being perceived. This responsibility lies with every physician. There is need for wider dissemination of this knowledge and for more physicians to assume the rôle of teachers.

Your reception room can and will serve as a medium and you can make it an effective factor in the education of the public. It will require only a little thought and time on the part of physicians. A few suggestions and thoughts are advanced by way of illustration.

Pictures.—Adorn some of your reception-room walls with pictures of Pasteur, Lister, Osler, Welsh, Banting, and other recognized investigators. Then on a card type a short biographical sketch of each man and state his outstanding discovery and what that has meant to modern medicine and public health.

Magazines.—Place upon the reading table approved magazines and articles that impart medical truths and medical information. The following are a few suggestions: *Hygeia,* bulletins on diphtheria, cancer, quackery, propaganda for reform, public health bulletins, etc. If you will write in, a list of suitable literature printed by the American Medical Association will be sent you.

Membership Certificate.—Display your certificate of membership attesting to your affiliation with your county and state medical organizations (new this year). In doing so you impart the existence of your county medical society and reflect your professional standing.

Use your reception room to educate the public. It can be made a powerful factor, a convincing factor and teacher in health education.

* * *

IVY EXHIBIT

Members are requested to urge their senators and assemblymen to visit the Ivy Exhibit on Animals' Contribution to Human Health on exhibition in Sacramento. This exhibit, as Editor Kress has commented in previous issues, visualizes impressively that which has been contributed toward health conservation and disease prevention by scientific research and study. Seeing this exhibit should convince legislators and others that laws should not be enacted to hinder or prevent continuation of such scientific investigations.

* * *

NO SUCH THING AS STANDING STILL

"Physicians can be divided into two great groups: there are those that are learning and those that are forgetting, those that each year know more and those that each year know less. There seems to be no third group, those that are stationary.

"A few physicians increase in knowledge from within and grow from their own doing. These are the innate

investigators. The rank and file require outside help to grow and to progress. Books, meetings, contacts, discussions, teachers, are our armamentarium of progress. Like the 'spring tonic' of past days, all of us need some of this medicine, at least annually, better if it comes more frequently. A large majority of physicians know their need and seek treatment. Postgraduate instruction is a potent prescription to this end" (*Journal of the American Medical Association*).

The foregoing is one of the thoughts and objectives underlying the program now being supervised by the Association to provide postgraduate opportunities for its members. Plans are being developed for the expansion and extension of this program. The end sought is to make these opportunities available to all members in convenient centers in the State. Will you coöperate?

HEROES FOR SCIENCE

Medical history records numerous instances where physicians in the interest of science have undergone physical risks and suffering, and even met death, in research investigations and studies. Would that the public might be truly informed as to these heroes for science.

These reflections were kindled anew after reading in the December, 1934, *Archives of Internal Medicine* the personal and physical reactions of A. W. Blair, M. D., of University, Alabama, who deliberately arranged to be bitten by a female spider Lactrodectus mactans.

The following are a few extracts of his personal observations and those of his associates:

At 10:45 a. m. he sustained the bite.
11:18 a. m. Pain extending up arm and chest.
11:55 a. m. Definite epigastric pains.
12:00 noon. Fall in blood pressure and weak pulse.
12:45 p. m. Agonizing pain in abdomen, back and legs. Taken to the hospital.
1:00 p. m. In profound shock, pulse uncountable.
1:15 p. m. In excruciating pain. Pulse 150; labored respirations.

November 13—An evening and night of extreme suffering in spite of morphin, face swollen, eyes red and watery, albumen in urine.

4 p. m. Pain, flushed, swollen face, tongue coated, fetid breath, nauseated, tense abdomen.

November 14—Restless night—rheumatoid pains in leg, sweating, and weakness, abdomen tense.

November 15—Home in ambulance.

November 20—All symptoms cleared up.

These few extracts impart but a meager picture of what occurred in this eight-day period recorded in five printed pages of clinical notes. They do, however, add one more name to the roll of heroes for science.

"IF YOU FAIL US WHERE SHALL WE TURN?"

This was the question recently propounded by a governor while he was addressing a medical meeting, and he went on to say:

"We don't pay much attention to the heroes of medicine who have done wonderful things. Your profession needs to take definite steps to keep the public well informed of the progress of medicine and instruct the people how to discover the men most competent to practice the healing art.

"Every time a citizen strays into the hands of a quack or an incompetent practitioner he comes away with a lowered opinion of the title 'Doctor.' It would be a great day if some time a layman could open the door of any physician's office and know in this State the standards are the highest and the title of 'Doctor' cannot be usurped by any ambitious fellow, half-trained in medicine and improperly grounded in the essentials of medical education."

This is a direct challenge to organized medicine. It can be answered by efforts directed toward the securing of a qualification law for all who seek to attend the sick. In this quest we will have the support of all thinking persons. Every member is urged to aid to attain that goal, for we shall not fail the public. A preliminary draft of a proposed qualification law has been sent to every county society for study and comment.

MAILING LISTS

The Association now has a list of all licensed physicians in California—some eleven thousand. This list is in the form of addressograph plates, containing the names of our members as well as the names of physicians who are not members. It is revised monthly.

Members desiring to mail reprints, questionnaires, literature, etc., to California physicians can arrange to secure this mailing list, or have envelopes addressed at the Association's offices. A very reasonable charge is made to cover the cost of labor.

CHANGE OF ADDRESS

Members are urged to notify the State Secretary of changes in their address.

Every month copies of this JOURNAL are returned because the post office reports the member has moved. This entails an expense, because the post office charges for notices of non delivery. So won't you please aid in avoiding this expense by sending in a post card giving your new address? Last month it cost the JOURNAL $16 because members failed to report their new address.

YOUR OFFICE AS A HEALTH CENTER

There is great need for extended application of preventive health measures. Information at hand evidences that the people do not receive nor do the physicians give preventive advice and treatment in the extent that society should receive and benefit from its administration.

It is true that patients are not always able to pay the usual fee for this advice and treatment. It is also true that many physicians have idle time on their hands. In several States the following plan is in operation.

The physicians announce that on certain days and during certain specified hours, outside of regular office hours, they will examine, advise and treat patients unable to pay the usual fees for chest examinations, tuberculin tests, vaccination toxoids and typhoid immunizations, and other prophylactic measures for a reduced fee.

Physicians arrange to be in their offices during these fixed hours and in groups, as is done in clinic, these preventive services are rendered.

These special hours are advertised by an educational campaign in the press before Parent-Teacher Associations and in notices sent to parents under the auspices of the county society.

Where these special office hours have been arranged physicians report pleasing results and increased income. At seventy-five cents, or a dollar or some such cash fee, many men have increased their income by $15 to $30 in these special hours.

The subject may well be considered by county societies with a view to adopting the plan.

ETHICS

The principles of medical ethics and the provisions in the constitution and by-laws of county and state medical associations governing the conduct of members have enabled the medical profession to maintain a high morale within its membership. These two provisions have stood the test of time, and are accredited as having been important factors in maintaining a high standard of professional integrity and dependability. They insure to the public sound and safe principles of practice and also assure the public a sustained interest in its health welfare.

The very nature of the profession's relationship to the public demands the observation and conforming to by its members of these guiding rules and principles of conduct. Without them public confidence could not be maintained.

A physician voluntarily affiliates with his medical society. One of the conditions of membership is that he agrees to accept and abide by the principles of

ethics and the rules of professional conduct and willingly agrees to place himself under their disciplinary provisions. No unreasonable demands are made. The provisions are such that any honorable physician promptly recognizes them as being an acceptable standard of integrity and honorableness and accepts them as agreeable ideals for his professional career.

Whenever a member, by his conduct and professional activities, infracts these principles and rules of conduct in a flagrant and persistent manner and no longer observes them in his dealings with the public and his patient, he becomes liable to disciplinary procedure. It is the same course that is observed by churches, lodges, fraternities, and clubs.

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WORTH PONDERING OVER

Tom and Tabby are said to have nine lives. The copy-cat has at least ninety and nine, is ubiquitous and, of all domestic animals, the most prolific and annoying.

* * *

Midnight electric light augments the students' responsibilities as well as pleasures. Unless handicapped by the softening influences of luxury he should accomplish vastly more than a Lincoln, whose evening reading was by firelight.

* * *

If it is true that a disconcerting beginning contributes to a favorable termination it is probable that this is through promoting greater caution on the way.

* * *

The foregoing are sayings of a septuagenarian.

There is a pressing need to recognize that governments exist to be supported by the people and not to support its people. Our perniciously acquired habit of endeavoring to "thumb" all we can from the government is fundamentally unsound. The same principle applies to organized effort as represented by our county and state medical organizations. The basic principle is "to give," not "get."

There are several famous health museums in foreign countries. There were none of note in this country till November, 1934. During that month a movement to give America its own museum of hygiene got under way in Chicago. With but one exception (a foreign exhibit) all the medical and health exhibits of the Century of Progress will be placed permanently in the large Rosenwald Museum. It should become a factor in teaching health.

COUNCIL MINUTES

Minutes of the Adjourned Two Hundred and Twenty-Ninth Meeting of the Council of the California Medical Association

The following minutes were approved by the Council at its two hundred and thirtieth meeting, held at San Francisco, Saturday, January 19, 1935.

Held in Assembly Room 214, Hotel Sir Francis Drake, San Francisco, Saturday, December 22, 1934, at 9:30 a. m.

Present.—Doctors Clarence G. Toland, president; Robert A. Peers, president-elect; Edward M. Pallette, speaker; T. Henshaw Kelly, chairman of the Council; Karl L. Schaupp, chairman of Executive Committee; Councilors W. W. Roblee, Carl L. Howson, Henry J. Ullmann, Fred R. DeLappe, Alfred L. Phillips, O. D. Hamlin, C. E. Schoff, Henry S. Rogers, Harry H. Wilson, C. O. Tanner, William H. Kiger, Morton R. Gibbons; Charles A. Dukes, chairman of Committee on Public Relations; George H. Kress, editor; F. C. Warnshuis, secretary; and Hartley F. Peart, general counsel.

Absent.—Dr. Junius B. Harris, because of illness.

1. **Call to Order.**—The two hundred and twenty-ninth adjourned meeting of the Council was called to order by the chairman, T. Henshaw Kelly.

2. **British Medical Association.**—The secretary stated that in reply to his request for information regarding the proposed tour of the United States by the British Medical Association, the American Medical Association advised that the British Association would be in this country during the first week of August, 1935, and planned to stop in San Francisco and Los Angeles.

Action by the Council.—On motion of Ullmann, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That a Committee of Eight be appointed by the president to arrange for the entertainment and comfort of the British Medical Association while in California.

The president appointed as members of the committee: Robert Peers (chairman), Harry H. Wilson, J. C. Geiger, R. Makinson, T. H. Kelly, Edward M. Pallette, W. W. Roblee, C. G. Toland, and F. C. Warnshuis.

3. **Western Hospital Association.**—A letter from the Western Hospital Association asking the California Medical Association to participate in a joint conference in February, was read.

The secretary was instructed to write the Western Hospital Association informing them that individual members are willing to aid wherever possible, but that the Association cannot participate in a joint conference.

4. **Letter of Appreciation.**—A letter was read expressing the appreciation of Doctor Toland of the Association's sympathy in the death of his mother.

5. **President's Badges.**—The secretary submitted drawings of the proposed president's badge and reported on the cost thereof.

Action by the Council.—On motion of Gibbons, seconded by Roblee and unanimously carried, the following resolution was adopted:

Resolved, That the matter of the purchase and presentation of badges to living past presidents of the Association be deferred.

6. **Goodall vs. Brite.**—Discussion was had of bill of Mr. Alfred Siemon for services rendered in preparing brief in case of Goodall vs. Brite.

Action by the Council.—On motion of Ullmann, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the secretary write a letter to Mr. Siemon stating that the condition of the Association's finances are such that only $500 can be allocated to services on brief and an additional $8.35 for costs.

7. **Corporate Practice.**—A bill for $466 for services of special investigators at Los Angeles incurred in the investigation of the corporate practice of medicine in Los Angeles by hospital associations was presented.

Action by the Council.—On motion of Schaupp, seconded by Peers and unanimously carried, the following resolution was adopted:

Resolved, That the expenditure of $466 be approved and the bill be paid.

It was stated that the work of the committee was now completed. Doctor Wilson submitted a brief report for the committee.

Action by the Council.—On motion of Pallette, seconded by DeLappe and unanimously carried, the following resolution was adopted:

Resolved, That the report of the committee be accepted and the committee be thanked for its activities and discharged.

8. **Committee of Five.**—The secretary submitted a report on the money advanced to the Committee of Five for the Medical Economics Survey stating that a total of $15,075.85 had been advanced to date and that a request had been received for $3000 more. Further discussion was deferred until later in the day.

9. **Basic Science Act.**—A letter was presented from the Yolo-Colusa-Glenn County Society regarding sponsorship of the proposed basic science act.

Action by the Council.—On motion of Kress, seconded by DeLappe and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be instructed to answer this communication stating that this is a matter which has been under consideration by the California Medical Association for a number of years. The Association recognizes the responsibility and will at all times be most willing to assist in the endeavors to secure desired legislation when a final decision is made by the Association concerning the form and content of said legislation.

10. **Ross-Loos Appeal.**—The Council resumed its deliberations of this appeal in executive session. Councilors not qualified to participate retired.

After mature deliberation the opinion and decision was adopted and concurred in without a dissenting vote.

Resolved, That we arise from executive session.

11. **Life Insurance Fees.** — A letter was presented from the Yolo-Colusa-Glenn County Medical Society regarding fees paid by different insurance companies for examinations. It was pointed out that at present there was no fee schedule approved by the California Medical Association upon which to base these fees. It was stated that inasmuch as the American Medical Association has a committee which is negotiating with the insurance companies regarding medical fees for examinations the Council deems it inadvisable at this time to give any special consideration to the subject until the report of the American Medical Association Committee is available.

12. **Chicago Medical Society.**—Letter and resolution of the Chicago Medical Society regarding the radio broadcasts under the title of "Doctors, Dollars and Disease" was presented.

Action by the Council.—On motion of DeLappe, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be instructed to reply to the letter.

13. **X-Ray Fee Schedule.**—Doctor Gibbons, member of the Committee on X-Ray Fee Schedule for Industrial Accident Work, submitted a progress report. Doctor Gibbons stated that until a fee schedule was adopted and approved by the Association there was no basis for working with the Industrial Commission.

Action by the Council.—On motion of Ullmann, seconded by Peers and unanimously carried, the following resolution was adopted:

Resolved, That the committee prepare a schedule and present it for adoption by the Council and that it then be offered to the House of Delegates.

14. **SERA.**—Doctor Roblee reported on the progress that had been made in medical care under the State Emergency Relief Administration in San Bernardino and Riverside counties. Doctor Roblee stated that the care in San Bernardino County carried hospitalization and that in Riverside it did not carry hospitalization.

A report was then submitted by Doctor Wilson on the conference held by the Committee on Emergency Relief of the Association and the SERA authorities in San Francisco, and he stated that another conference was scheduled for Monday, at which time a state plan for medical care in all counties would be considered.

Action by the Council.—On motion of Toland, seconded by Rogers and unanimously carried, the following resolution was adopted:

Resolved, That the progress report of the SERA Medical Advisory Committee be approved.

15. **Woman's Auxiliary.**—Doctor Roblee stated that in the past an allotment had been made to the Woman's Auxiliary each year for entertainment at the annual session and that $150 had been requested for entertainment at the next meeting at Yosemite.

Action by the Council.—On motion of Roblee, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the California Medical Association allocate $150 to the Woman's Auxiliary for entertainment expenses at the Yosemite session.

16. **Trustees to the American Medical Association.** Discussion was had of the distribution of trustees of the American Medical Association, and the following information was presented: There are two trustees within fifty miles of Chicago. There is one trustee in Minnesota, Ohio, Maryland, Massachusetts, Georgia, Oregon, and New York. The East Coast has three trustees, and the Southeast Coast one in Georgia. The Midwest has four trustees. The West Coast, one trustee, residing in Oregon. The large area west of Chicago and of Minneapolis from the Canadian border to the Gulf of Mexico and Mexico, and extending to the Pacific Coast, has but one trustee.

The following notice of the introduction of an amendment to the Constitution of the American Medical Association is hereby given:

WHEREAS, Because the large area and the long distances in the constituent states on the Pacific Coast make it practically impossible for one trustee to maintain intimate contact with the medical organizations of these states; and

WHEREAS, For similar reasons one trustee is unable to visit these several states and advise them in regard to Association policies and activities; and

WHEREAS, Such intimate affiliations would enhance the work of the American Medical Association and also that of the State Associations; therefore be it

Resolved, That the Reference Committee on Amendments to the Constitution and By-Laws prepare the following amendment to Article VI, Section 1, of the Constitution:

"Strike out the word 'nine' and insert therefor the word 'eleven,' thereby increasing the number of trustees from nine to eleven; and be it

Resolved, That the House of Delegates adopt the rule that one trustee shall be elected from the Fellows in California, one from the Midwest or southwestern part of the country.

Action by the Council.—On motion of Pallette, seconded by Kiger and unanimously carried, the following resolution was adopted:

Resolved, That notice of the contemplated action be sent to Doctor West and that the chairman of the California delegation present the proposed amendments to the Constitution of the American Medical Association to the House of Delegates of the American Medical Association.

17. **Recess.**—At this point a recess of the Council was declared for luncheon.

18. **Call to Order.**—The meeting was called to order by the chairman. Doctors William R. Molony, Sr., Alson R. Kilgore, Rodney Yoell, members of the Committee of Five, were present, and Professor Paul A. Dodd, director of survey.

19. **Committee of Five.**—Doctor Molony reported on the activities of the committee and stated that Doctor Kilgore had been appointed by the Survey Committee as a committee of one to present a plan for a voluntary health insurance plan; that Doctor Yoell, a Committee of One, to present plan for a compulsory health insurance plan; that each speaker of the Committee of Five would be allowed twenty minutes to present his views to the Council. Doctor Molony stated that Doctor Wilson, as secretary of the committee, would present the technical end of the discussion. Doctor Wilson then outlined the work of the committee briefly and suggested that Doctor Dodd present the technical work of the committee.

Doctor Molony presented the following digest of minutes of the meeting held at San Francisco on December 21, 1934:

"Present: Molony, Peers, Yoell, Kilgore, Mr. Lionel Browne of the Attorney-General's office.

"An extended discussion was had of various legal aspects of the outline of compulsory bill proposed by Doctor Yoell.

"Moved by Kilgore, seconded by Yoell, that the committee recommend that the Council place before a special meeting of the House of Delegates three propositions: (1) The adoption of a policy favoring immediate compulsory health insurance legislation. (2) The adoption of a policy of establishing private initiative (so-called voluntary) health insurance by the California Medical Association to such extent and as soon as may be done legally and practically. (3) That

the California Medical Association state its belief that the principle of insurance can be applied to sickness, it is acutely conscious of a number of difficulties in the way of extended application of this principle in California. It does not believe that these difficulties are insurmountable, but is impressed with the importance of further thorough study and investigation, and strongly deprecates hasty legislation.—W. R. Molony, Chairman of Committee of Five."

Doctor Dodd gave a detailed discussion and report on the actual working of the survey stating that delay had been occasioned by the difficulties encountered in perfecting plans with the SERA, by field workers and by the slowness of the return of questionnaires mailed in the State; that twenty-six counties had been completely surveyed and five counties were still incomplete. Doctor Dodd submitted a written report on the money expended, questionnaires distributed, hospitals and doctors contacted, etc., and stated that it would be possible to have a preliminary report ready by the middle of January and that in order to complete the survey and arrive at final conclusions, two to three months more would be necessary.

Doctor Dodd stated that he wished to go on record as to the spirit of coöperation and open-mindedness of the Committee of Five.

It was pointed out that in order to complete the survey and submit conclusions by the technical staff it would be necessary to have an additional appropriation of $7,500, bringing the total cost of the survey to the California Medical Association exclusive of printing, distribution and actuarial figures to $28,643.31.

At this point Doctor Yoell was requested to present his plan for compulsory health insurance.

Doctor Kilgore then presented a plan for voluntary health insurance, at the request of the Council, in written form.

Doctor Yoell then requested three minutes additional time to discuss some of the statements made by Doctor Kilgore in his discussion.

Action by the Council.—On motion of Ullmann, seconded by Roblee and unanimously carried, the following resolution was adopted:

Resolved, That Doctor Yoell be requested to present in writing his plan of compulsory health insurance in order that the members of the Council may have a clear idea of it.

Doctors Peers and Wilson then addressed the Council. Doctor Wilson stated that he considered it inadvisable to attempt to set the date of the meeting of the House of Delegates at this time and suggested that the matter of setting the date lie over until the January meeting of the Council, at which time the report of the Survey Committee in preliminary form would be available.

Action by the Council.—On motion of Pallette, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the Committee of Five be requested to make as full a report as possible at the January meeting of the Council.

20. **Addressograph.** — The secretary stated that at present the office had a hand addressograph and service covering only the members of the Association and that it was desirable to have a list of all licensed physicians and surgeons in California. Doctor Warnshuis stated that an addressograph could be installed at a cost of approximately $500; that since the cost of mailing journals was $70 monthly the initial cost would soon be absorbed by mailing the JOURNAL from the Association's list.

Action by the Council.—On motion of Dukes, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be authorized to purchase an addressograph and to compile a list of the non-member licensed physicians and surgeons in California, on approval of the Auditing Committee.

21. **Membership Record.**—The secretary stated that Remington-Rand had submitted an estimate of $403.50 plus cost of cards and table for a complete membership record file that would impart all necessary data on each member in a perpetuating form.

Action by the Council.—On motion of Kress, seconded by DeLappe and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be authorized to install the membership record file as outlined in bid of Remington-Rand Company, upon authorization of the Auditing Committee.

22. **Financial Statement.** — Financial statement for the month of November, 1934, was presented by the secretary, and on motion of Peers, seconded by Dukes, was approved.

The chairman of the Council reported on the loan negotiated by officers of the Association.

Action by the Council.—On motion of Peers, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the action of the chairman of the Council and the secretary-treasurer in negotiating a loan of $5,000 be approved, and that the chairman of the Council and the secretary be authorized to negotiate further loans to provide for the Association's financial needs.

23. **Report of Auditing Committee.**—The report of the Auditing Committee was presented. It was stated that since no meetings of the Executive Committee had been held, it had not been approved by that body as provided in the Constitution and By-Laws. It was stated that a meeting of the committee would undoubtedly be held prior to the January meeting of the Council and that the report should be submitted to the Executive Committee for its approval before presentation at the January meeting of the Council.

The recommendations attached to the report of the Auditing Committee were read as follows:

"Your Auditing Committee recommends that the following actions be recorded by the Council:

1. That all requests for expenditures of funds not included in the budget be referred to the Auditing Committee for their approval and recommendations before an appropriation is made by the Council.

2. That the secretary-treasurer-business manager be instructed to confer with the James H. Barry Company in the matter of publication costs of CALIFORNIA AND WESTERN MEDICINE and report his findings at the next meeting of the Council.

3. That the secretary-business manager be instructed to take over the business details of reprint sales and secure contract for printing and fixing the reprint sales price, and report his findings and recommendations to the Council.

4. That no commission be paid for the sale of exhibit space at the annual meeting.

5. That the JOURNAL wrapper return notice be changed so as to conserve expenditure of funds required each month upon unclaimed JOURNALS returned by the Post Office Department.

6. That the secretary be requested to secure prices for card index membership record and to report the estimated cost of installing such record to the Council for its consideration.

7. The Auditing Committee recommends to the Council that it rescind its action providing frames for the 1935 membership certificates because of the cost involved.

8. The Auditing Committee has devised a new voucher-check and auditing blanks which will enable the Association to have a more compact record of financial transactions and disbursements.

9. That the secretary be requested to obtain from Ernst & Ernst an estimate of the cost for annual audit of the Association's financial transactions.

Action by the Council.—On motion of Dukes, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the recommendations attached to the report of the Auditing Committee as outlined above be approved.

24. **Audit of Association Accounts.**—A letter from Ernst & Ernst, accountants, submitting an estimate on auditing the accounts of the California Medical Association and the Trustees Of The California Medical Association at a rate of $30 per diem for senior

accountants and $20 per diem for assistant accountants, with a maximum fee of $250, was read.

Action by the Council.—On motion of Ullmann, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the recommendation of the secretary be approved and Ernst & Ernst be employed to audit the books of the Association and the Trustees Of The California Medical Association.

25. **Subscription Price of Journal to Libraries.**—Discussion was had of a reduced subscription price for the JOURNAL to medical libraries throughout the country.

Action by the Council.—On motion of Peers, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That medical libraries be charged the regular subscription price for the JOURNAL except where otherwise authorized by the Council.

The secretary was instructed to notify the medical libraries.

26. **Ivy Reprint.**—The secretary reported that ten thousand of the Ivy reprints on "Contributions of Animals to Health" were at present being printed, but that it was decided not to use the illustrations, since they proved valueless when reproduced.

27. **California and Western Medicine.**—The secretary stated that he had secured estimates on publication of the JOURNAL in similar form and number from various sources and that the costs compared favorably with the present cost of printing.

28. **Reprints of Journal Articles.**—The secretary outlined a method of handling reprints direct through the Association's offices.

Action by the Council.—On motion of Kress, seconded by DeLappe and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be authorized to institute the system of handling reprints direct from the Association's office.

29. **Publication of Papers Presented at Annual Sessions.**—A letter was presented from the secretary of the Section on General Medicine regarding delay in publication of papers presented at the annual session. Full discussion was had. It was pointed out that the large number of papers presented at each session and the necessity for diversification in subject-matter in the make-up of each issue of the JOURNAL precluded preferential publication.

It was the sense of the Council that the selection of papers be left to the Publications Committee.

30. **Advertising Agents.**—Discussion was had of the advertising secured by agents for publication in the JOURNAL.

Action by the Council.—On motion of Kress, seconded by Phillips and unanimously carried, the following resolution was adopted:

Resolved, That Doctor Wilson discuss with Mr. Guttman the matter of advertising sales in the JOURNAL and that the Council await his recommendations.

A letter from Mr. Flynn, northern advertising agent, was presented in which he suggested that he attend the Yosemite session in order to contact advertisers personally and aid them in presenting a successful commercial exhibit at the Yosemite session.

Action by the Council.—On motion of Wilson, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the secretary be authorized to make the necessary arrangements for Mr. Flynn's presence at the Yosemite session.

31. **Legislation.**—The general counsel discussed prospective legislation, with special reference to the county hospital bill, hospital service insurance bill, laboratory bill, and amendments to the Medical Practice Act.

Action by the Council.—On motion of Dukes, seconded by Peers and unanimously carried, the following resolution was adopted:

Resolved, That the Executive Committee be instructed to consider these measures and to instruct Mr. Peart.

Discussion was had of the case of Pacific Employers' Insurance Company versus the Insurance Commissioner. The general counsel submitted a copy of the Brief of Amici Curiae.

Action by the Council.—On motion of Rogers, seconded by Dukes and unanimously carried, the following resolution was adopted:

Resolved, That the matter be left to the judgment of the general counsel and that a maximum sum of $100 be allowed for printing costs (no attorney's fees to be included in this amount).

The general counsel stated that the brief in the case of Francis vs. Nelson was now ready.

Mr. Peart stated that consideration should be given to provisions in county society constitutions which would provide for a tie-in with the State Society in matters of professional conduct and discipline.

The general counsel submitted a progress report on malpractice insurance problems with special reference to a plan for a reciprocal exchange.

The general counsel stated that the State Federation of Labor had declared itself as in favor of legislation utilizing county hospital for maternity cases.

The forthcoming Constitutional Convention was brought to the attention of the Council.

32. **Adjournment.**—At this point, adjournment was taken until 9 a. m. Sunday.

* * *

Present.—Clarence G. Toland, Robert A. Peers, E. M. Pallette, T. Henshaw Kelly, Karl L. Schaupp, W. W. Roblee, Carl R. Howson, Henry J. Ullmann, Fred R. DeLappe, Alfred L. Phillips, C. E. Schoff, H. S. Rogers, Harry Wilson, W. H. Kiger, Morton R. Gibbons, C. A. Dukes, F. C. Warnshuis, Hartley F. Peart.

Absent.—O. D. Hamlin, C. O. Tanner, J. B. Harris, George H. Kress.

33. **Call to Order.**—The adjourned meeting of the Council was called to order by the chairman.

The chairman announced that the Council would meet with the members of the Interim Committee and representatives of the dental profession at 10 a. m.

34. **Committee of Five.**—Further discussion was had of the appropriation for the completion of the survey now being conducted by the Committee of Five.

Action by the Council.—On motion of Toland, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That there be allocated to the Committee of Five for use in conducting the survey on the cost of medical care such added amount as was requested by the committee to bring the total sum to not exceed $28,700 for the entire survey; disbursements to be approved by the Auditing Committee on regular voucher check.

35. **Interim Committee.**—T. Henshaw Kelly, chairman of the Council, announced that the members of the Interim Committee and representatives of the dental profession had arrived for conference.

Doctor Kelly then presented Senator Dan Williams, Senator Edward H. Tickle; Roland J. French, president of the Western Hospital Association; Roy Green and Ernest Sloman, members of the Legislative Committee of the Dental Profession; T. R. Sweet, president of the Dental Association; and Professor Paul A. Dodd, director of survey and assistant professor of economics, University of California at Los Angeles. Upon his arrival Celestine J. Sullivan, coördinator secretary of the Interim Committee, was also presented to the Council.

The chairman requested Doctor Wilson and Doctor Dodd to present the present status and future progress of the survey so that those present might be conversant with this matter before further discussion was had.

After this was done, the chairman invited Senator Williams, Senator Tickle, Doctor French, Doctor Sweet, Doctor Green, Doctor Sloman, and Mr. Sullivan to discuss any means of using the work of the survey in the work of the Senate Interim Committee or any other matters that they desired to speak about.

After a full and helpful discussion it was understood that the Council would meet on January 19 and set a date for a special meeting of the House of Delegates of the California Medical Association in February, at which time usable material would be available from the survey and a decision on policy could be made by the California Medical Association.

In the meantime the Committee of Five and the Council would maintain contact with the Senate Interim Committee, and any material in the office of the California Medical Association or the survey would be available to the latter committee.

36. **Call to Order.**—The Council was called to order after the conference with the Interim Committee for the consideration of further routine business.

37. **Date of Council Meeting.** — Consideration was given to the most opportune time for the next meeting of the Council.

On motion of Pallette, seconded by Roblee and unanimously carried, the following resolution was adopted:

Resolved, That the next meeting of the Council be held on January 19, 1933, in San Francisco.

It was stated that the date of the special meeting of the House of Delegates would be discussed at the January 19 meeting of the Council.

38. **Committee of Five.**

Action by the Council.—On motion of Schaupp, seconded by DeLappe and unanimously carried, the following resolution was adopted:

Resolved, That an invitation be extended by the Council and the Committee of Five that a member of the dental profession be designated to sit with and advise the Committee of Five in its future deliberations.

At this point the chairman read the following note, which was sent to the Council by Dr. Paul A. Dodd:

"As director of the research staff for the Committee of Five, I wish to express my deep appreciation to the Council for its vote of confidence evidenced by the approval of the final request for appropriations and lay before it the pledge that every economy possible be exercised in the expenditure of this appropriation. Not a dollar will be spent that is not absolutely necessary in the completion of our task."

39. **Legislation.**—The general counsel discussed further contemplated legislation.

The advisability of defining hospital insurance by an amendment to the Political Code was brought up.

Action by the Council.—On motion of Rogers, seconded by Ullmann and unanimously carried, the following resolution was adopted:

Resolved, That the general counsel prepare a bill defining hospital insurance as health and accident insurance and clarifying the law.

40. **San Diego Health Insurance Plan.** — A letter from the San Diego Medical Society, together with a plan for health insurance under the Fraternal Insurance Law, was presented.

It was stated that the plan had been voted down by the San Diego Society since the letter had been forwarded to the State Association and consideration was, therefore, unnecessary.

41. **Expenditures.**—Discussion was had of expenditures of the Association, with special reference to the legal department.

Action by the Council.—On motion of Toland, seconded by Pallette and unanimously carried, the following resolution was adopted:

Resolved, That a committee, consisting of Dr. W. W. Roblee, as chairman, and Doctors Morton R. Gibbons and W. H. Kiger, be appointed by the chairman of the Council to make a survey of all legal expenses of the California Medical Association for the past five years, and bring in a report at the January meeting of the Council with such suggestions as to the future policy as may be deemed best. That the necessary expense incident be paid by the California Medical Association.

42. **Public Welfare.**—After discussion of the value of scientific medicine to public welfare, on motion of Dukes, seconded by Ullmann, the following resolution was adopted:

Whereas, It is deemed desirable to transmit to the Governor of California the desire of the California Medical Association to make available to him the services of this Association in all matters relating to public health; therefore be it

Resolved, That the president and the secretary be instructed to convey to Governor Merriam, in a communication, that all the facilities, information and experiences of the California Medical Association are at his command whenever the Governor feels the need of dependable advice and information in matters related to public health, preventive medicine and medical care.

43. **Membership Certificates.**—Doctor Howson stated that since the Council had decided, on account of the expense entailed, not to furnish frames with the membership certificates, that it would be desirable to arrange with some firm to keep a supply of suitable frames on hand which might be secured both in San Francisco and Los Angeles at a reasonable rate.

44. **Minutes of the Council.**—Discussion was had of the present procedure in handling Council minutes.

Action by the Council.—On motion of Pallette, seconded by Ullmann and unanimously carried, the following resolution was adopted.

Resolved, That the present procedure in approving Council minutes be dispensed with and that in the future the first draft of the minutes prepared by the secretary and chairman be mailed to all members of the Council within seven days of the meeting, for correction, which draft should be returned to the State office within five days; that the corrected draft be remailed to councilors within five days, and if further corrections are received they be again remailed; or if corrections are not received within five days after final revision the minutes be approved for publication.

It was stated that minor changes in wording would not necessitate resubmission of minutes to councilors.

45. **Approval of Minutes of the Council.**—Minutes of the adjourned two hundred and twenty-ninth meeting of the Council held on October 6, 14, and November 10, 1934, were presented to the Council.

Action by the Council.—On motion of Phillips, seconded by Roblee and unanimously carried, the following resolution was adopted:

Resolved, That the minutes of the two hundred and twenty-ninth adjourned meeting of the Council held on October 6, 14, and November 10, be approved, and published in the January Journal.

46. **Medical Economics.** — The secretary asked instructions from the Council as to whether or not the county societies should be informed as to authentic literature regarding medical economic questions.

It was the sense of the Council that copies of information coming from the Bureau of Medical Economics of the American Medical Association be sent to members of the Committee of Five and all county societies in order that they may be informed on those questions.

47. **House of Delegates.**—The question was raised as to seating of delegates at the contemplated special meeting of the House of Delegates. The constitutional provision on seating of delegates was considered.

Action by the Council.—On motion of Pallette, seconded by Phillips and unanimously carried, the following resolution was adopted:

Resolved, That those delegates be seated who were regularly elected for the 1934 session and that the county secretaries be instructed in accordance with the by-laws that the delegates regularly elected for the 1934 session at Riverside will be seated.

48. **American Medical Association.**—Discussion was had regarding the advisability of inviting the American Medical Association to San Francisco in 1937. Action was deferred.

49. **Adjournment.**—There being no further business the meeting adjourned.

T. Henshaw Kelly, M. D., *Chairman.*
F. C. Warnshuis, M. D., *Secretary.*

COMPONENT COUNTY MEDICAL SOCIETIES

MONTEREY COUNTY

The regular meeting of the Monterey County Medical Society was held on January 4 at the Hotel Del Monte.

After the dinner the officers for the coming year were installed, and President Hugh Dormody turned the gavel over to Dr. L. P. Davlin, who outlined plans for the year. Some SERA problems were discussed, and the feeling was that all the doctors should be permitted to treat these patients. Communication has been made with the State Association president and president-elect regarding action in this matter. The meeting adjourned until February 8.

W. H. Lawler, *Secretary.*

ORANGE COUNTY

The forty-seventh annual banquet of the Orange County Medical Association was held in the Santa Ana Country Club at 7 p. m. January 8. There were approximately one hundred members and guests present.

A turkey dinner was served by the Club, and during the meal amplified recordings were heard. After the dinner the guests were entertained by a group of selected numbers rendered by the Santa Ana Elks Double Quartette.

Dr. D. A. Harwood acted as master of ceremonies. Mrs. H. G. Huffman, the president of the Woman's Auxiliary, gave a concise review of the activities of the organization during the past year. *Recent Changes in the Practice of Medicine* was the subject of the address given by Dr. H. G. Huffman, the retiring president. He spoke on strides made in the science of medicine and urged that we keep abreast of the times in both the science and the economics of medicine.

Mr. J. Frank Burke, the editor and publisher of the Santa Ana *Daily Register,* was the invited guest speaker. His subject was *Can Medicine Be Successfully Socialized Alone?*

Following the installation of officers for 1935 the meeting adjourned. Waldo S. Wehrly, *Secretary.*

PLACER COUNTY

The Placer County Medical Society held its January meeting at the Freeman Hotel in Auburn on the 12th at 8:30 p. m. The meeting was called to order by Dr. Louis E. Jones, president. In addition to President Jones, there were the following members and visitors:

Members — Paul D. Barnes, Robert H. Eveleth, W. M. Miller, James F. McAnally, J. A. Russell, W. A. Vinks, Michael F. Flatley, R. C. Atkinson, Robert A. Peers, D. M. Kindopp, and Mildred E. Thoren.

Visitors—Dr. Emile Holman, professor of surgery, Stanford University Medical School, San Francisco; Dr. C. E. Schoff, councilor of the eighth district, Dr. Frank Scatena, Dr. F. A. MacDonald, Dr. H. M. Kanner and Dr. Orrin Cook, all of Sacramento; Dr. Ward of Auburn and Dr. Ellert E. Lundegaard of Weimar.

The following applications for membership were read for the first time: Dr. Vernon W. Padgett of Allegany and Dr. Ellert E. Lundegaard of Weimar.

Following routine business the president introduced Dr. Emile Holman, who addressed the Society upon *The Treatment of Pyogenic and Tuberculous Pulmonary Suppuration — Clinical and Experimental Observations.* He illustrated his talk with lantern slides. Doctor Holman brought out the following points, based upon experimental work done by him, and also upon his surgical experience.

Experimental evidence was presented, indicating that infected emboli invariably produce marked pneumonitis, followed frequently by abscess in the parenchyma of the lung. Similar abscesses were also produced when a sterile embolus lodged in the lung of an animal which harbored an infection elsewhere in the body, such as an infected compound fracture or an infected operative wound. Such secondary infection of an embolized area of the lung by circulating organisms probably explained a certain number of postoperative pulmonary abscesses.

Pulmonary suppuration due to the tubercle bacillus can be produced in the dog by the introduction of a tubercle infected embolus in the jugular vein. The pathologic changes initiated by such an embolus were first a pneumonitis, followed successively by a caseous consolidation and a liquefaction of the pneumonic area with abscess formation.

In the presence of pyogenic or tuberculous suppuration of the lung there invariably occurs a marked dilatation of the bronchial artery leading to the suppurative area. This dilatation of the bronchial artery with its systemic blood pressure undoubtedly accounts for the occasional massive and fatal arterial hemorrhage that occurs in the presence of pyogenic and tuberculous abscesses.

Following ligation of the pulmonary artery to a lobe, there develops a dilatation of the bronchial artery and a filling up of the pulmonary artery through its capillary connections with the bronchial artery. Large pulmonary emboli in the pulmonary artery produce the same dilatation of the bronchial artery and its capillary communications with the pulmonary artery. This is undoubtedly a clinical occurrence also.

In the treatment of pyogenic pulmonary abscesses, adequate drainage is most imperative. Whether achieved through a bronchus by postural drainage or through a surgical incision is immaterial, but it must be adequate as evidenced by a diminution in cough, in sputum and in fever. A trial of two to four weeks of absolute bed rest and postural drainage is warranted before advising surgical intervention. If there is a large opening into a bronchus with profuse drainage from the abscess, every effort should be made to avoid establishing a second large opening to the outside through the chest wall. A through and through passage from chest wall to trachea interferes markedly with the normal cough reflex, thus preventing evacuation of surrounding bronchi. The resultant atelectasis precludes the expansion of normal pulmonary tissue around the abscess and thus interferes with the obliteration of the abscess.

The apical tuberculous pulmonary abscess must also be obliterated to effect a cure. If pneumothorax is impossible, selective surgical collapse is indicated rather than an extensive complete thoracoplasty. This may be achieved by complete resection of first, second, and third ribs and partial resection of fourth and fifth ribs. Resection of the transverse processes is also an occasional aid as well as partial resection of the lower third of the scapula. Conservation of good lung may be very important in the face of bilateral disease. This, selective surgical collapse aims to do.

The following members and visitors took part in the discussion: Doctors Holman, Peers, P. D. Barnes, Kindopp, Atkinson, Thoren, Scatena, Cook, and MacDonald. Robert A. Peers, *Secretary.*

SAN BERNARDINO COUNTY

The San Bernardino County Medical Society met at the San Bernardino County Charity Hospital on Tuesday evening, January 8, at eight o'clock.

The meeting was opened by the president, with sixty-five members and guests present.

Doctor Wylie briefly discussed the General Medical Aid Corporation. The motion passed by the Council was called for. The secretary read the motion: "That the society disapprove of the General Medical Aid Corporation in that they refuse to fill out any of the G. M. A. reports." It was moved, seconded, and passed by the society. Doctor Abbott thought that in the future the society should have nothing to do with similar organizations until investigation by the Committee on Public Relations.

The applications of Dr. J. S. Hayhurst and Dr. H. Milford Nelson were favorably voted upon.

Dr. C. G. Hilliard, chairman of the SERA Medical Advisory Committee, gave a short report, commend-

ing the members upon their splendid coöperation in carrying out the SERA medical program. Mr. Thoreson, who was unable to attend the meeting was also pleased, Doctor Hilliard stated. Members were cautioned to use cheaper drugs of the U. S. P., and not the costly proprietary remedies.

Due to an order from the State SERA Director, the fee schedule was reduced to the old CWA fees of $1.25 for all office visits and $1.75 for home visits, etc. This charge is effective from January 9, 1935. Relief work in general is up in the air.

The cost for doctors' services, not including nurses, hospitalization, etc., for the four weeks compiled, was one per cent of the total amount spent by the SERA in this county. Doctor Hilliard lamented the fact that the State organization had not given us more support for the program we worked so hard for.

The program of the evening was then given: *Can a Conscientious Doctor Keep Out of Jail?* by Mrs. Kemper Campbell, LL. B., Professor of Medical Jurisprudence, College of Medical Evangelists.

A. E. Varden, *Secretary.*

SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms, January 3, in Stockton. This was called to order at 8:15 p. m. by Dr. P. B. Gallegos.

Dr. P. B. Gallegos then installed the incoming president for 1935, Dr. C. A. Broaddus, who gave a short address concerning his plans for 1935. He reported the formation of an Executive Committee and told of a meeting in which plans for the ensuing year had been discussed.

The scientific program of the evening was opened by Dr. Don King, associate professor of surgery at Stanford, who discussed *Injuries Involving the Shoulder Joint.* This was a very fine paper, and much information was compressed into a very brief and well-planned article. Doctors Sanderson, Vieira, English, and Dameron discussed the presentation. The second paper of the evening was presented by Dr. Robert Sarborough, also from the department of surgery at Stanford, who gave a paper on *Treatment of Minor Complaints of the Rectum and Anus.* This led to a lively discussion.

Dr. J. P. Hull spoke about objections to a new textbook which was being planned for use in the public schools, the opposition being led by cultists who disapprove of a chapter on the germ theory of disease. This matter was referred to Dr. D. R. Powell and his committee for action. The meeting was adjourned at 10:30 p. m. and refreshments were served.

G. H. Rohrbacher, *Secretary.*

SANTA BARBARA COUNTY

The annual dinner meeting of the Santa Barbara County Medical Society was held on January 14 at the El Mirasol Hotel. There were present sixty members and thirteen guests.

Ballots for the election were collected at the door by the tellers, which greatly reduced the time usually taken up for balloting.

Previous to the dinner the members and their guests were treated to refreshments and music.

During the dinner service the results of the initial balloting were read and the final ballots were then distributed, and the following officers were then declared elected: President, E. Kost Shelton; vice-president, P. A. Gray; vice-presidents-at-large, H. G. Hanze, M. T. Duncan; secretary, W. H. Eaton. Councilors: H. E. Henderson, Hugh Freidell, O. C. Jones (north of Gaviota).

Doctor Markthaler then called upon President-elect Shelton to conduct the remainder of the meeting.

After short introductory remarks, Doctor Shelton called upon the following visitors for a few remarks: Judge Atwell Westwick, Attorney Harrison Ryon, and Dr. Harry V. DeGighne of Juneau, Alaska.

It was moved, seconded, and unanimously carried that Dr. William T. Barry be elected an honorary member of the Society.

Doctor Shelton then introduced the speaker of the evening, Dr. L. L. Stanley, medical director of the State prison at San Quentin. Doctor Stanley's talk was intensely interesting and educational. Lantern slides of the prison were shown.

William H. Eaton, *Secretary.*

SONOMA COUNTY

The Sonoma County Medical Society held its January meeting on the 10th of the month.

The meeting began with a clinic on tuberculosis, held in the offices of Doctors Shipley and Hines, 533 Mendocino Avenue. Some twenty-six patients from different parts of the county were present and examined. Dr. Sidney J. Shipman of the faculty of the University of California Medical School and Dr. F. McGrain of the Silvarado Sanitarium conducted the clinic, with the assistance of quite a number of the Sonoma County physicians. This work was materially helped by the public health nurses, Miss Carlson of the State Tuberculosis Association, Miss Sacry of the High School, Miss Peterson of the county school service, and Miss Martin of the Red Cross. Mr. N. F. Higby, president of the State Tuberculosis Association, was also an observer. All present, including the patients, seemed to enjoy the meeting.

At 7 p. m. a dinner was served in the private dining room of the Occidental Hotel, which was attended by thirty members and guests.

After dinner the Society was called to order by President F. O. Butler.

There being no further important business, the president introduced Doctor Shipman, who gave a very instructive discourse upon *Pulmonary Tuberculosis,* which was illustrated by lantern slides made from x-ray films. This is the second meeting of the kind held by the Sonoma County Medical Society, and all present expressed the opinion that the time was well spent.

President Butler appointed the following personnel to serve on the committees for 1935:

Legislative Committee—H. S. Rogers of Petaluma, F. E. Sohler of Healdsburg, and J. H. McLeod of Santa Rosa.

Public Relations Committee — J. Leslie Spear of Santa Rosa, M. L. Lewis of Petaluma, and L. W. Ray of Santa Rosa.

Physiotherapy — C. M. Fleissner of Santa Rosa; E. Vieira of Sebastopol, and H. J. Wright of Healdsburg.

Cancer Committee—A. A. Thurlow of Santa Rosa, H. S. Gossage of Petaluma, and B. B. Bacheldor of Sebastopol.

W. C. Shipley, *Secretary.*

TULARE COUNTY

A regular meeting of the Tulare County Medical Society was held on Sunday evening, December 16, 1934, at Motley's Cafe, Visalia, Dr. John R. Hicks, presiding.

Dr. E. R. Zumwalt reported that he had discussed the formation of a unit of the Public Health League with the dentists and nurses' representatives and would have plans later for a meeting to consider organization.

A letter was read from the Tulare County SERA relative to possible projects for SERA workers in medical fields, and action was taken to signify our willingness to coöperate in this matter.

Dr. Frank Kohn then submitted the recommendations of the Nominating Committee as follows: President, Ray Rosson of Tulare; vice-president, I. M. Lipson of Visalia; secretary-treasurer, K. F. Weiss of Visalia; censor, S. S. Ginsberg of Visalia (1935–1936); delegate, K. F. Weiss of Visalia; alternate, the elected president.

The meeting was then opened for nomination of officers. Doctor Furness moved that the recommenda-

tions of the Nominating Committee be unanimously elected as the schedule of officers for 1935. This was seconded by Doctor Betts, and carried.

Dues for the coming year, 1935, were voted at $10 local, and $10 for State.

Following the business meeting, Dr. George F. Schenck of Los Angeles presented a practical paper on everyday genito-urinary problems. The title of his paper was *Renal Infections*. A series of lantern slides was used to present the mode of infection, routes, its progress, the pathology, symptoms, diagnosis, and treatment of renal infections. A round-table discussion followed this worthwhile paper.

KARL F. WEISS, *Secretary.*

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VENTURA COUNTY

The Ventura County Medical Society held its annual dinner and election of officers at the Ventura County Country Club, December 11, 1934, at 7:30 p. m.

A business meeting was held after the dinner. Nomination and election of officers was held, with those in office for 1935, as follows: President, A. Strong of Santa Paula; vice-president, Fred A. Short of Ventura; secretary-treasurer, A. A. Morrison of Santa Paula; delegate, G. C. Coffey of Ventura; alternate, W. Felberbaum of Santa Paula.

FRED A. SHORE, *Secretary.*

* * *

The regular monthly meeting of the Ventura County Medical Society was held at the County Clinic Building on Tuesday, January 8.

The meeting was called to order by President Strong, who turned the meeting over to Dr. W. S. Clark. Doctor Clark introduced Dr. Steele F. Stewart of Los Angeles, who presented a very instructive paper on *Indications for Surgery of the Sympathetic Nervous System.* Doctor Stewart then presented two reels of pictures which quite aptly illustrated the technique for performing lumbar and cervical sympathectomies.

A business meeting followed.

Communications: A letter from the Committee on Legislative Activities of the American Medical Association; State Secretary's monthly letter; invitation from the Santa Barbara society to members of this society to attend their annual meeting and dinner.

Doctor Felberbaum was appointed to determine the cost of a machine with which the monthly meeting notices could be printed. Methods for increasing the attendance were discussed.

Doctor Morrison was appointed program chairman for February, and Doctor Homer for March.

A. A. MORRISON, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (11)

Alameda County.—DeBert W. Connell, John R. Henry, George T. Honaker.

Imperial County.—W. W. Apple, John L. Barker, Florence Mary Dunlap.

Merced County.—Harry M. Grayman.

Napa County.—Orval L. Kirkle.

Sacramento County.—Walter N. Becker.

San Francisco.—Mario Isnardi.

San Joaquin County.—E. W. Thomas.

Transferred (3)

Henry Hoagland, from Los Angeles County to Riverside County.

A. R. Dickson, from Los Angeles County to Calhoun County, Michigan.

William A. Key, from San Francisco County to San Mateo County.

Resigned (3)

Jacques R. Gray, from San Francisco County.

Edward E. Hethcock, from Los Angeles County.

Dorothy J. Stark, from San Francisco County.

In Memoriam

Bucher, William Henry. Died December 30, 1934, age 60. Graduate of Medico-Chirurgical College of Philadelphia, 1896. Licensed in California in 1912. Doctor Bucher was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Dannenbaum, Sydney Ray. Died at San Francisco, December 23, 1934, age 53. Graduate of the University of California Medical School, 1906, and licensed in California the same year. Doctor Dannenbaum was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Hennemuth, John Louis. Died at Modesto, December 9, 1934, age 66. Graduate of the University of Minnesota Medical School, Minneapolis, 1890. Licensed in California in 1891. Doctor Hennemuth was a retired member of the Stanislaus County Medical Society, the California Medical Association, and the American Medical Association.

✝

Kylberg, Hjalmar. Died at Merced, December 30, 1934, age 69. Graduate of the California Eclectic Medical College, Los Angeles, 1893, and licensed in California the same year. Doctor Kylberg was a member of the Merced County Medical Society, the California Medical Association, and the American Medical Association.

✝

Luttrell, Peter Harrison. Died at San Francisco, December 17, 1934, age 56. Graduate of Cooper Medical College, San Francisco, 1908, and licensed in California the same year. Doctor Luttrell was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Neighbors, Clarence Anson. Died November 14, 1934, age 54. Graduate of the Kansas City Medical College, 1905. Licensed in California in 1924. Doctor Neighbors was a member of the Orange County Medical Society, the California Medical Association, and the American Medical Association.

OBITUARY

Clarence A. Neighbors
1880-1934

Clarence A. Neighbors was born in McPherson, Kansas, August 23, 1880. He was educated at McPherson Academy, Ottawa, University, 1902; M. S. from same, 1905; Kansas City Medical College, 1905. California license, 1924; member of Orange County Medical Association since 1929. Practiced at Emporia, Kansas, until 1920; Ottawa, Kansas, until 1927. Doctor Neighbors came to Anaheim in 1927 because of his health, and resumed practice in that place in 1929, where he continued to practice until his death on November 14, 1934.

Doctor Neighbors was a member of the Orange County Medical Association, California Medical Association, Long Beach Eye, Ear, Nose and Throat Club, and American Academy of Ophthalmology and Otolaryngology.

He was a member of the Baptist Church of Fullerton, a Mason-Shriner, an Elk, and a Lion. Former president of Lyon County Medical Association and trustee of the Baptist College of Kansas.

Doctor Neighbors married May Beatty, May 8, 1907. He is survived by his widow and three children.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. PHILIP SCHUYLER DOANE President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

Canadians to Attend Atlantic City.—Mrs. Robert W. Tomlinson, National Auxiliary president, in a letter just arrived reminds us that the Canadian Medical Society is meeting jointly with the American Medical Association at the annual convention in Atlantic City in June. This makes the occasion one of far more than ordinary importance and gives to this great national medical gathering an interesting international flavor. Among the National Auxiliary plans for the entertainment of the feminine visitors is a gala evening specially honoring the wives of the Canadian doctors attending. Every effort to greet and entertain our national neighbors from the north will be made. Many of our members are united by bonds of personal friendship with Canadian families of the medical profession, and many more happy contacts should spring from this opportunity of meeting together.

* * *

National Auxiliary Officer Here.—Mrs. Eben J. Carey, treasurer of the Woman's Auxiliary to the American Medical Association, was a recent visitor to the Coast with her husband, Doctor Carey, dean of Marquette University School of Medicine, and their young daughter. Mrs. Carey has already distinguished herself in the Auxiliary by work of that fine caliber that makes the cogs of organization machinery click in tune. As state president of the Wisconsin Auxiliary last year and as chairman of Credentials and Registration during the national convention at Milwaukee in 1933, she established a record for reliability and efficiency that will not be easy to equal.

* * *

Associate Membership Dues.—A communication from San Diego County announces that several of the wives of physicians in Government service have lately joined the Auxiliary there as associate members. This opens the possibility of many valuable additions from that source, since the United States Army and Navy forces number many doctors in their medical corps, not only at the base in San Diego, but wherever they are stationed in organized counties of the State. Their wives and those of internes are eligible to associate membership under the new revisions of the State constitutions adopted last May.

The question of associate membership dues has come up for consideration with the inclusion of this group. Since there is no provision in the State constitution covering them, it has been suggested that the fixing of an amount of one dollar or less be left to the discretion of the county boards concerned. The State Auxiliary president has ruled that until such time as a provision is drafted to cover this point there is no need for the county to remit any part of their associate membership dues to the state treasurer.

* * *

Program Suggestions.—While the year is still young and new county officers and committee chairmen are settling themselves in the official seats, we wish to submit two programs planned for this year by two counties with the country's breadth between them. We present them with the hope that they may aid either in idea or inspiration some other county whose work is yet in the formative period. The first comes from our own State and has been worked out by Mrs. John V. Barrow and her committeemen. Under the general title of *What a Doctor's Wife Should Know,* there will be discussed a series of topics, each by a qualified speaker, for fifteen minutes, at each of the general meetings of the year. This project is an attempt at self-education among the members themselves. The topics include:

1. A comparative study of the educational qualifications of doctors of medicine, health officers, dentists, osteopathic physicians, chiropractors, naturopaths.
2. Clinics—Public and Private.
3. Nutrition.
4. Animal Experimentation.
5. Food Handlers.
6. The Problems of Narcotics and Intoxicants.
7. Eugenics.
8. Security for the Child.
9. Epidemic and Contagious Diseases.

The second plan comes from Georgia and was worked out by the Fulton County Auxiliary. Their year's program includes the following subjects, one each for the main meeting of the month:

1. Status of Mother Welfare in Georgia.
2. Medicinal Plants of the Georgia Indians.
3. Proper Lighting and Sight Conservation.
4. The Story of the Christmas Seal—and the Menace of Tuberculosis.
5. Medical Legislation.
6. The History of Medicine as Related to Motherhood.
7. The Contributions Chemists have Made to Health.
8. Quackery and the Auxiliary's Place in Refuting It.
9. Study of the Medical Laws of Georgia and of the Work of the State Board of Health.

* * *

County Auxiliary Reports

Alameda County.—The regular meeting of the Woman's Auxiliary to the Alameda County Medical Association was held at the Women's Athletic Club on Friday, November 16, 1934. Hostesses for the luncheon, which preceded the meeting, were Mrs. Forest Kracaw, assisted by Mrs. A. W. Henry and her committee. At the business session the ticket submitted in September by the Nominating Committee was voted upon, and the following officers declared elected: Mrs. Robert Sutherland, president; Mrs. Harold Smithies, president-elect; Mrs. Harold Trimble, vice-president; Mrs. Charles Peters, recording secretary; Mrs. Harold Carpenter, corresponding secretary; Mrs. Walter Adams, treasurer; and Mrs. Leonard Barnard, Mrs. Lloyd Kindall and Mrs. Hobart Rogers, directors. These officers, together with the three directors held over from last year, Mrs. Walter Dickie, Mrs. A. W. Henry and Mrs. O. B. Jensen, form the board of the Alameda Auxiliary for the next eighteen months.

A Revisions Committee, headed by Mrs. Thomas J. Clark, submitted amendments to the county constitution, which were voted upon and accepted. These change the county year and annual election of officers from December to May and thus make the county and state calendar coincide. Following the business meeting, a program of impersonations and characterizations was given by Alice Weaver, one of the Alameda members, and greatly enjoyed by all her listeners for their cleverness and discernment.

Mrs. A. W. Henry, *Publicity Chairman.*

* * *

Los Angeles County.—The Los Angeles County Auxiliary held its annual meeting on December 18, 1934, in the Rainbow Isle at the Mayfair. Nearly two hun-

*As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

dred attended this closed session when the work of the year just closing was reviewed and the activities of the year ahead were planned. When luncheon was over, Mr. Thad Harvey, operatic tenor, delighted everyone with his fine singing. Mrs. J. Martin Askey gave a ten-minute review of current medical events, stressing the recent award of the Nobel Prize for scientific achievement to the three American physicians—Murphy, Minot, and Whipple.

Mrs. John V. Barrow, the president, then began the business session by calling on the various officers and committee chairmen for their annual reports. Several short speeches were made from the floor in appreciation of the *Christmas Courier,* the first edition of a small news sheet sponsored by the State Auxiliary. A vote of thanks to the retiring officers—Mrs. A. Brockway, Hospitality chairman; Mrs. Charles Futch, first vice-president; and Mrs. Clifford Walker, recording secretary—was expressed. The Revisions Committee, Mrs. James F. Percy, Mrs. Philip S. Doane, and Mrs. H. Waldo Spiers, then read and submitted to vote the proposed amendments to the by-laws, which were unanimously accepted.

Among the changes effected by these amendments is the transfer of the time of the annual meeting and election of officers from December to May, thus making the county calendar concurrent with that of the State. There will be no election in May of the present year, the new officers and board continuing in their posts for the next year and a half. Mrs. Philip S. Doane, state president, took the chair for the installation of officers as follows: Reëlected for president, Mrs. John V. Barrow; first vice-president, Mrs. William A. Swim; second vice-president, Mrs. Walter H. Boyd of Long Beach; treasurer, Mrs. H. E. Schiffbauer; recording secretary, Mrs. A. J. Annis. The four new directors for the board are: Mrs. Clinton D. Hubbard of Huntington Park, Mrs. Roy Miller of Pasadena, Mrs. Franklin Farman, and Mrs. Philip Stephens. Mrs. W. O. Leach of Glendale and Mrs. Mark Glaser remain on the board from last year.

To plan constructively for the coming year and to enable both the Auxiliary and each individual member in it to gain the fullest benefit from their mutual association, Mrs. Barrow has distributed among the membership a circular with a series of such questions as: What business, professional, or artistic training have you had? What are your special educational or cultural interests? To what other organizations do you belong? In which of the Auxiliary's activities would you be willing to serve? What type of program do you prefer? The answers to these circulars are now being compiled and will greatly aid the Auxiliary in planning its programs and the work of the year.

Mrs. Elmer Belt, *Corresponding Secretary.*

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Riverside County.—The following officers were elected at the December meeting of the Woman's Auxiliary to the Riverside County Medical Association: For president, Mrs. Hervey S. Faris; first vice-president, Mrs. W. W. Roblee; second vice-president, Mrs. T. A. Card; treasurer, Mrs. C. R. Geith; recording secretary, Mrs. Arthur Miller; and corresponding secretary, Mrs. H. J. Wickman.

* * *

Sacramento County.—The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. Frederick N. Scatena, with the president, Mrs. Howard Hall, presiding. Reports from the treasurer and the corresponding secretary were received. Mrs. F. Krull of the Library Committee of the County Hospital reported that Mrs. Scatena had recently donated thirty new books and that more were needed; that the patients expressed much enthusiasm over the books and wanted some with pictures. It was agreed to give $5 to the purchase of new books and also to procure a rubber stamp to mark the entire collection.

A report from Mrs. E. O. Brown's committee that $5 be given the Margaret Howard Memorial Fund for scholarship at the Junior College was approved. The report further recommended that $2.50 be given in the future to the Sacramento Orphanage as a memorial gift on the death of an Auxiliary member in place of sending flowers; and that a note of sympathy be written to any member in whose family a death had occurred. The report was accepted and is to be used as future procedure under such circumstances.

The Nominating Committee, composed of Mrs. William K. Lindsay, Mrs. H. R. Johnson and Mrs. J. H. Davis, read the following ticket: Mrs. Frederick N. Scatena, president; Mrs. H. Kanner, first vice-president; Mrs. A. K. Dunlap, second vice-president; Mrs. William Van Den Berg, recording secretary; Mrs. F. P. Brendel, corresponding secretary; Mrs. T. Binkley, treasurer; and Mesdames C. B. Jones, J. T. Vance and W. A. Reckers, directors, to serve for two years.

The meeting then adjourned for a social hour. Christmas music was sung by Rudolph Caffaro and Miss Mary Lusich, accompanied by Mrs. Zue Geery Pease. Bridge was enjoyed, and gifts of white elephants were distributed to each one present. Delicious refreshments were served by the hostesses assisting Mrs. Scatena, who were the members of the Executive Board, from a table with decorations indicative of the Christmas season.

Sarah L. Brendel, *Corresponding Secretary.*

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San Joaquin County.—At the January meeting of the Woman's Auxiliary to the San Joaquin County Medical Society, action was taken to sponsor bringing the Dresden Exhibit on Eugenics to Stockton. Other organizations of women will be invited to coöperate with the Auxiliary in making this undertaking a success.

Ella B. Conzelmann, *Secretary.*

NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D.....Associate Editor for Nevada

* * *

E. E. HAMER, Carson City President
R. O. SCHOFIELD, Boulder City.....President-Elect
C. E. SECOR, Elko.....First Vice-President
HARRY W. SAWYER, Fallon.....Second Vice-President
HORACE J. BROWN, Reno.....Secretary-Treasurer

COMPONENT COUNTY MEDICAL SOCIETIES

CLARK COUNTY

The Clark County Medical Society held the first meeting of the new year Tuesday, January 8, at the Sal Sagev Hotel. Dr. R. D. Balcom, newly elected president, presided over the meeting. Other officers elected at the December meeting were Dr. R. O. Schofield, vice-president, and Dr. Hale B. Slavin, secretary-treasurer.

The scientific program for the evening was presented by Dr. A. G. Clark of Boulder City on the subject of *Renal Tuberculosis.* Doctor Clark gave a concise and instructive discussion of his subject, which was followed by comments by Doctors Van Meter, Jannson, Odell, Balcom, and Woodbury.

There was no business of any importance up for consideration. Doctor Van Meter announced, however, that Dr. John Vruwink of Los Angeles, would present a paper relative to certain phases of his specialty, obstetrics, at the February meeting of the Society.

Hale B. Slavin, *Secretary.*

WASHOE COUNTY

The Washoe County Medical Society held its first monthly meeting of the year on Tuesday night, January 8, at the State Building. Dr. H. A. Paradis of Sparks called the meeting to order, and introduced the incoming president, Dr. M. A. Robison of Reno, one

of our veteran members. Doctor Paradis very graciously thanked the Society for its fine coöperation during his term of office. Dr. M. A. Robison then was seated and assured the Society that he would do his utmost to keep the Society up to the high standards of the past.

The December minutes were read and approved, including the statement of a public accountant who had audited the secretary-treasurer's books, finding a balance in the treasury of $48.96, as of December 11, 1934.

There was some difference of opinion among some members that a physician could, by paying the amount of county society dues (without paying the State dues), be considered a member of the local county medical society. To settle the matter authoritatively, the secretary wrote Dr. Olin West, secretary and general manager of the American Medical Association, Chicago, with reference to this point. Doctor West, in a reply of December 28, 1934, said: "I do not have available a copy of the constitution and by-laws of the Nevada State Medical Association, but I am practically sure that it contains specific provisions to the effect that the members of the component societies of the Nevada State Medical Association shall be members of the State Association. The component county medical societies in each state are supposed to receive their charters from the State Association concerned. It is, of course, implied in this fact that the members of the county societies are also members of the State Association when their names are forwarded for enrollment and their membership dues or assessments are paid to the secretary of the State Association.

"I think you will find in the by-laws of the Nevada State Medical Association, and probably in the by-laws of your own county medical society that, as secretary, you are required to transmit annual dues or assessments for all members of the Washoe County Medical Society to the secretary of the Nevada State Medical Association.

"It is my personal opinion that membership in the Washoe County Medical Society involves membership in the Nevada State Medical Association."

The above letter was read in meeting, as in itself without motion settled the question whether or not a physician by simply paying county medical dues, could be allowed voice and vote in the local county society if his dues were not paid to the State Society.

President Robison appointed a legal committee (if such should be needed) to work in the interest of the Society at the forthcoming meeting of the Nevada State Legislature. The committee named was: Dr. Horace J. Brown (chairman), to be assisted by Drs. MacLean, Harrison, DaCosta, and Hamer.

A letter dated December 19, 1934, from Vera Wilson, R. N., secretary of the Nevada State Nurses' Association, Reno, was read, making inquiry with reference to a point of ethics by a registered nurse to accept work as nurse under an osteopathic or chiropractic physician. The matter of advisability from a point of medical ethics was debated pro and con. Acting upon the advice of the members present, the secretary's letter to the secretary of the Nevada State Nurses' Association was as follows:

"Your letter of the 19th of December, 1934, setting forth the query as to the question if regular nurses employed by osteopaths or chiropractors would be considered a violation of ethics from the viewpoint of the regular profession.

"The same was discussed at the regular meeting of the Washoe County Medical Society. Opinions varied as to the advisability of nurses accepting patients under the professional care of osteopaths or chiropractors while still seeking duty from the regular profession. In general, that question must be decided by each nurse individually. Yet at the same time, a graduate nurse seeking employment with a patient under a regular physician would be liable to prejudice herself in the estimation of the regular medical profession if it were known that she held herself open to the employ of chiropractors or osteopaths."

There being no further routine business, the president called on Dr. Lawrence Parsons, pathologist of St. Mary's Hospital, who gave an excellent paper on *Blood Transfusion.*

An abstract of the paper follows:

The paper was divided into the following heads: I. History of Transfusion; II. The Blood Groups; III. Selection of the Donor; IV. Indications for Blood Transfusion; V. Technique of Transfusion; and VI. Untoward Reactions in Blood Transfusion. The paper was illustrated by means of a chart showing the classification of the blood groups and representing also the appearance of the test slides, using Group II and Group III sera, Moss's classification and the method of Dr. Walter V. Brem, first published in 1917.

The first successful transfusion was made by Jean Baptiste Denys, physician to Louis XIV, on June 15, 1667, using the blood of a sheep and giving it to a young man suffering from repeated hemorrhages. Similar transfusions were done between animals by Richard Lower, F. R. S., in England in 1666 and so characteristically described by Samuel Pepys in his diary. Untoward results and fatalities soon occurred and the practice was stopped by laws in England and on the Continent. Numerous unsuccessful attempts were made throughout the nineteenth century, after nearly 150 years, during which time they were not attempted. Only after the discovery and classification of the blood groups by Dr. Karl Landsteiner, Jansky, and Moss did transfusion become successful. Landsteiner received the Nobel Prize in Medicine in 1930 for his work, which was largely responsible in making blood transfusion the success it now is.

The classification of Landsteiner, Jansky, and Moss were discussed. The racial incidence of the blood groups and the subject of subgroups was presented. The groups in infancy and the time of appearance of the agglutinins were presented. The relationship of hemagglutination to hemolysis and the significance of the latter in transfusion reactions were also discussed.

Following the presentation of the above fundamental material the remainder of the paper followed the outline previously given. Great emphasis was given to the technique of cross-matching of the blood of the donor with the serum of the recipient immediately prior to the transfusion in order to prevent as far as possible fatalities due to the assumption that persons of the same group are necessarily compatible for transfusion.

This concluded the business of the evening and the Society adjourned in the regular order.

THOMAS W. BATH, *Secretary.*

Is not public health merely a matter of water supplies, ventilation, sewage, clinics, drains, street-cleaning, garbage, infectious diseases, public health nurses, flies, dirt, slums, and serums? True it is that these items are all in it. But they no more constitute public health than mere paint, canvas and brushes constitute art; or mere iron ore and smelters constitute architecture; or rods, lines and nets constitute the fishing industry; or axes and wire rope constitute lumbering; or schoolhouses and textbooks constitute education. All these items are merely the tools of the arts. The tools of an art are essential to the art; but they do not constitute the art. Art is the result achieved; it is that object toward which the tools merely perform the shaping of the path.

That public health originated in the attempt to relieve crude physical suffering and especially to achieve this only by preventing disease, does not take from its present or future immensely greater importance. That it has reached already its present outstanding influence is proof enough of its inherent strength, a strength derived wholly from its truth—that is, its correspondence with, not things just dreamed about, but things that *are*—not with just *some* things in the universe but with *all* things.

The common objective of medicine and of public health is the reduction of human misery due to disease and death. The one devotes itself to the relief and cure of those already suffering, the other to prevention. Since neither fully succeeds, each must continue to supplement the other. Each in its own field has made enormous advances from each its own angle. Coöperation is increasing as each understands the other's problems better.—H. W. Hill, M.D.

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

Annual Congress on Medical Education and Licensure, Chicago, February 18-19, 1935. William D. Cutter, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Yosemite National Park, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

Pacific Coast Surgical Association, Santa Barbara, February 21-23, 1935. Edgar L. Gilcreest, M. D., 384 Post Street, San Francisco, Secretary.

Medical Broadcasts*

American Medical Association Health Talks. — The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, central standard time.

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San Francisco County Medical Society. — The radio broadcast program for the San Francisco County Medical Society for the month of February is as follows:

Tuesday, February 5—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Whooping-Cough.
Tuesday, February 12—Being a legal holiday, there will be no broadcast.
Tuesday, February 19—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: A Forgotten Plague.
Tuesday, February 26—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Hydrophobia.

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Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of February is as follows:

Saturday, February 2—KFI, 9 a. m. Subject: Medicine and Human Progress.
Saturday, February 2—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, February 5—KECA, 11:15 a. m. Subject: Medicine and Human Progress.
Saturday, February 9—KFI, 9 a. m. Subject: Medicine and Human Progress.
Saturday, February 9—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, February 12—KECA, 11:15 a. m. Subject: Medicine and Human Progress.
Saturday, February 16—KFI, 9:00 a. m. Subject: Medicine and Human Progress.
Saturday, February 16—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, February 19—KECA, 11:15 a. m. Subject: Medicine and Human Progress.
Saturday, February 23—KFI, 9:00 a. m. Subject: Medicine and Human Progress.
Saturday, February 23—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, February 26—KECA, 11:15 a. m. Subject: Medicine and Human Progress.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

American Urological Association. — The American Urological Association will hold its annual meeting on June 24 to 28, inclusive, at the Palace Hotel, San Francisco. William E. Stevens, M. D., 870 Market Street, San Francisco, is chairman of the Committee on Arrangements.

American Board of Radiology to Meet on Pacific Coast. — B. R. Kirklin, M. D., secretary-treasurer of the American Board of Radiology, Rochester, Minnesota, has sent out a notice that the American Board of Radiology has decided to hold a meeting on the west coast about the middle of May, 1935, at which time candidates will be examined for certificates. Additional information concerning these examinations was given in this column in the January issue.

Professor Lindner of Vienna to Give Eye Course in San Francisco.—Professor Dr. Karl Lindner, chief of the eye clinic in Vienna, successor to Professor Fuchs, will be in San Francisco March 10, and will give a series of five lectures and demonstrations on selected eye topics under the auspices of the Stanford Medical School. A charge sufficient to defray his expenses only will be made. Eye specialists interested in this course can communicate with Dr. Hans Barkan, Stanford University Hospital. Telephone: West 8000.

Fifty-Third Course of Popular Lectures by Stanford.—Stanford University School of Medicine announces the fifty-third course of Popular Medical Lectures (illustrated) to be given at Lane Hall, north side of Sacramento Street, near Webster, on alternate Friday evenings, at 8 p. m. sharp. All interested are cordially invited to attend. Program follows:

Friday evening, January 4—Brain Activities, James M. D. Olmsted, Ph. D.
Friday evening, January 18—Poliomyelitis, Harold K. Faber, M. D.
Friday evening, February 1—Dinitrophenol in the Control of Obesity, Maurice L. Tainter, M. D.
Friday evening, February 15—Quinin: The First Hundred Years, Nathan Van Patten, Director of University Libraries.
Friday evening, March 1—Present-Day Relationships Between Medicine and Industry, William P. Shepard, M. D.
Friday evening, March 15—Growth and Development in Infancy, Mary H. Layman, M. D.

Pacific Institute of Tropical Medicine.—Dr. Alfred C. Reed, professor of tropical medicine and director of the Pacific Institute of Tropical Medicine at the University of California, has been elected to the post of secretary-treasurer of the American Society of Tropical Medicine.

Announcement of Doctor Reed's new position was made following a meeting of the organization in San Antonio, Texas. At that meeting Dr. Herbert G. Johnstone, associate in tropical medicine at the University of California, and Mrs. Margaret K. Iverson, submitted a report on the incidents of intestinal amebic infections among men and women engaged in the preparation or handling of food in San Francisco.

This study of amebiasis was made with the coöperation of Dr. J. C. Geiger, head of the health department of San Francisco. It was found that food handlers in the city are more free from amebiasis than the general population. The percentage of infection among the former was 2.9 and among the latter between 5 and 10.

Famous Medical Journal Editor Dies—Dr. Lewis Stephen Pilcher.—Dr. Lewis Stephen Pilcher, scholar and editor for half a century of the oldest surgical journal in the United States, the *Annals of Surgery,* died recently at eight-nine years of age. Country school teacher, country practitioner, naval surgeon, student of tropical disease, anatomist, professor of surgery, editor, bibliophile, patriot—these nouns indicate a few of his many interests and activities over a long and intensely useful life.

Lewis Stephen Pilcher entered the University of Michigan at the age of thirteen, and took his bachelor's degree at seventeen, the youngest matriculant and the youngest graduate of that great institution. His master's degree was added within a year; and in that same year he entered upon medical study. This was in 1863, when the Civil War was raging. The next year found him with enough medical knowledge to volunteer as a hospital steward and throw himself into the thick of service to the sick and wounded. Then back to the University of Michigan and the doctor's degree in 1866. . . . In 1884 he became editor of the *Annals of Surgery,* which position he has occupied to the present day. This publication, beginning in 1884, was acquired in 1897 by J. B. Lippincott Company. The editorial policy and censorship of advertising have never been relinquished by the editor. If we add to the fifty years of the *Annals of Surgery* the seven years of the *Annals of Anatomy and Surgery,* and its predecessor which he inspired and dominated, this period of medical editorship establishes him as the dean of medical editors in the United States, if not in the world.

Food Seizures Heavy in November.—The United States Department of Agriculture (Office of Information) reports as follows: Nearly sixteen thousand bushels of apples bearing poison residues exceeding safe limits were seized in November, the Food and Drug Administration reports. . . .

Fifty-two shipments of decomposed or filthy cream, totaling more than 3,000 gallons, and 11,676 pounds of unfit butter, were confiscated and destroyed. The cream was in every instance en route to creameries to be made into butter. . . .

Among seafoods, canned shrimp predominated in number of seizures made, there being sixteen totaling four thousand cases; canned mackerel was next with eleven seizures covering 4,300 cases; and one consignment of mongrel whitefish was seized because of parasitic worms. Other unfit commodities confiscated were decomposed shell eggs, decomposed ripe olives, canned corn containing caterpillars, whisky containing vinegar flies, canned tomatoes in active fermentation, filthy sesame seed, insect-infested figs, and dirty canned spinach.

A shipment of 2,400 quart bottles of absinthe labeled "Pernod Liquer," originating in Belguim, was confiscated during November at New York. Absinthe contains wormwood, a deleterious ingredient, and therefore violates the Federal and Food and Drugs Act.

In the drug field, seizures were effected of shipments of chloroform, tincture of opium and witch-hazel extract, all found below standard. "Patent" medicine seizures included a consignment of "Fink's Magic Oil," shipped from Cincinnati, to Newburgh, New York, labeled as a treatment for rheumatism, toothache, earache, sore throat, pains and aches, diarrhea, chills and fever, cholera, cholera morbus, colic, mumps, catarrh, asthma, eczema, boils, ringworm, and bronchitis. These claims, the Government alleged, were false and fraudulent. Other medicines seized because of label claims that could not be substantiated, were "Terraline" and "Terraline Creosote" for pulmonary disorders and bronchial catarrh; "Power's Asthma Relief" for asthma and hay fever; a "candy worm expeller" for intestinal worms and tapeworms; and a "veterinary balm" for various disease conditions of livestock.

Senate Committees:

Public Health and Quarantine:
Leonard J. Difani, Chairman—Riverside County.
Walter McGovern—San Francisco County.
Frank W. Mixter—Tulare County.
Harry L. Parkman—San Mateo County.
Edward H. Tickle—Monterey County.
Dan E. Williams—Mariposa County.
Sanborn Young—Santa Clara County.

Hospitals and Asylums:
Herbert W. Slater, Chairman—Sonoma County.
Ed Fletcher—San Diego County.
William F. Knowland—Alameda County.
Harry L. Parkman—San Mateo County.
Harry A. Perry—Humboldt County.
Charles F. Reindollar—Marin County.
Sanborn Young—Santa Clara County.

Insurance:
Dan E. Williams, Chairman—Mariposa County.
George M. Biggar—Mendocino County.
Charles H. Deuel—Butte County.
Leonard J. Difani—Riverside County.
Ray W. Hays—Fresno County.
Henry McGuinness—Siskiyou County.
Harry L. Parkman—San Mateo County.
Charles F. Reindollar—Marin County.
Jerrold L. Seawell—Placer County.
Ralph E. Swing—San Bernardino County.
W. R. Sharkey—Contra Costa County.

Missing.—Dr. George H. Bigelow, formerly Commissioner of Public Health of the Commonwealth of Massachusetts, and present Director of the Massachusetts General Hospital, Boston, Mass., may be a victim of amnesia.

Description: Six feet tall; weighs approximately 175 pounds; has deep blue eyes; heavy shock of black hair closely cut, slightly gray at the temples. He is of rangy build. When he left his home he wore a soft brown felt hat, a black overcoat with a velvet collar, a brown suit, and tan rubber-soled shoes, and a soft white shirt. He is forty-four years of age. He wore a square silver wrist watch with a leather strap, and carried a brown pigskin brief case.

He disappeared December 4, 1934, having left his home in Milton, Mass., for his office in the Moseley Building at the Massachusetts General Hospital, Boston, Mass. He was to appear at 8 p. m., Tuesday night, December 4, 1934, at the Staten Island Hospital to speak, and on Wednesday at the American Society for the Control of Cancer in New York City.

The finger prints of Dr. George H. Bigelow are in the possession of the Department of Public Safety of the Commonwealth of Massachusetts. Hospitals are requested to finger-print all amnesia victims unidentified, forwarding the same to Colonel Paul G. Kirk, Commissioner of Public Safety, State House, Boston, Mass.

Warns of Danger in Raw Pork Which May Cause Trichinosis.—The caution to "cook pork well" is again repeated and emphasized by the United States Department of Agriculture. . . . Trichinosis is a disease of humans caused by small threadworms known as trichinae. These parasites occur occasionally in the muscle tissue of pork. When infested pork is eaten by human beings in a raw or insufficiently cooked state, the parasites are set free in the digestive tract, where they grow and multiply. Ultimately the new generation invades the muscles of their human victims and produces the disease, trichinosis, which may be exceedingly painful and long drawn out. In extreme cases, it causes death.

"There is no danger whatsoever from pork, so far as trichinosis is concerned, if care is taken to cook well all pork and products containing pork muscle tissue," says Dr. Benjamin Schwartz, department zoölogist. "Pork" he states, "is one of the most appetizing articles in the human diet. Only a very small proportion of the hogs in this country are infested with trichinae, but it is dangerous to eat raw or improperly cooked pork. These parasites in pork are rather easily destroyed by cooking. Dead trichinae cannot produce trichinosis. To avoid trichinosis, follow the simple precaution: Cook all pork well done."

Address by Nobel Prize Winner.—Dr. Leroy Sherry, retiring chief of staff, presided at the annual dinner for members of the medical staff of the Pasadena Hospital at the hospital. More than 150 attended.

Dr. Thomas Hunt Morgan of Caltech, Nobel prize winner (1933) in biology presented an illustrated lecture on the principles of heredity which are particularly related to the field of medicine.

Some of the laws of inheritance and the complexity of these laws which have been definitely established by research, were described by Doctor Morgan and illustrated by charts showing the transmission of inherited traits in plants, animals, and human beings.

Doctor Morgan hopes that the biologist will be able to tell the physician who discovers a dominant inherited trait in his patient which other traits will be present although they are not observable. This scientific assistance would be very helpful to medical science.

The financial statement of the hospital was given by Mr. Ruddock. Miss Alice Henninger, superintendent, stated that 4,062 patients were cared for by the Pasadena Hospital in 1934, receiving 38,005 days of hospital service. There were 2,565 operations performed in the hospital, and 306 babies born there. Miss Henninger also stated that 1,009 patients received free or part-pay service given by the hospital welfare and endowment funds amounting to about $25,000.

Comprehensive reports of the work of the committee of the hospital staff were given by the committee chairmen: Drs. Frank W. Hodgdon, J. L. Busby, John Dunlop, J. H. Breyer, P. S. Doane, E. M. Johnstone, C. C. Snyder, Alvin G. Foord, George Dock, and R. K. Gustafson.

Dr. Harry Markolf, the new chief of staff, and Dr. John Chapman and Dr. Leland Hunnicutt, the officers appointed for the year 1935, took over the duties and responsibilities for the hospital staff.

The United States Public Health Service.—In the Surgeon-General's report to Congress it is stated there is yet no evidence that the depressed economic conditions of the past few years have lowered the general health of the people of the United States, according to the Surgeon-General of the United States Public Health Service. This information is presented in his annual health accounting to Congress which reports the activities of his organization for the 136th year of its existence. While death rates are available from year to year as an index to health, the Surgeon-General has not relied upon these rates alone, but has instituted special studies of actual sickness over a period of several years, beginning in 1929, in ten localities where the depression has been most severe. These studies show higher sickness rates in the economic group rated in comfortable circumstances in 1929, but subsequently reduced to the lower economic class. The most important reasons given for the continuation of general good health are the vast work of the relief agencies and the fortunate absence of widespread epidemics.

It is interesting to note that for the calendar year 1933 the general death rate, 10.5 per 1,000 population, was the lowest ever recorded in the United States; and the rate for 1932 was next lowest, 10.8 per 1,000. While health conditions remained comparatively good for the first half of 1934, the death rates for many localities were higher than those for the preceding year.

In spite of the economic conditions, the number of deaths from tuberculosis continued to decrease. For the calendar year 1933 the death rate was 59 per 100,000 population—5 per cent below the previous low minimum. The typhoid fever death rate was also the lowest ever recorded — only 3.5 deaths per 100,000, which was 8 per cent below the previous minimum. The diphtheria rate dropped to 3.9 per 100,000—also the lowest death rate ever recorded by the Public Health Service for this disease.

Although there were no widespread epidemics during the year under report, there were three major local epidemics. An unusual outbreak of amebic dysentery occurred in Chicago in 1933 during the Century of Progress Exposition. Many people became ill after returning to their homes, but no secondary epidemic was reported outside of Chicago. Approximately 700 cases occurred or originated in Chicago. The epidemic was caused by defective plumbing. An outbreak of epidemic encephalitis, with some unusual clinical features, occurred in St. Louis and the surrounding country with about 1,100 cases and more than 200 deaths; and California had an epidemic of poliomyelitis (infantile paralysis) in 1934.

Smallpox, the principal scourge of mankind in the last century, still caused more than 75,000 deaths in countries sufficiently advanced in health matters to keep vital statistics records; but less than forty of these deaths occurred in the United States, although nearly 7,000 cases of the disease were reported. Several European countries have advanced so far in preventive activities that they did not have a single case of smallpox in 1933.

The birth rate continues to decline in the United States. The rate in 1933 was 16.4 per 1,000 population, as compared with 17.4 in 1932. Fortunately, however, the infant death rate also continues to decline. In 1933 there was one death in the first year of life for every seventeen children born, while in 1915 one out of every ten died.

In reporting on world health conditions, which were comparatively good, the report calls attention to the absence of epidemics, such as influenza. The occurrence of cholera was confined to Asia and the adjacent islands, where there were about 100,000 cases with 48,000 deaths, as compared with 75,000 cases and 39,000 deaths in 1932.

Plague caused more than 77,000 deaths in 1933 as compared with about 50,000 in 1932. This disease, the dreaded "black death" of past ages, appeared in all the great land divisions of the world except Australia. Two cases occurred in California, where the disease is kept smouldering in the ground squirrels. . . .

The airplane is now an important possible source of infection to this country; and during the fiscal year 3,668 airplanes carrying 26,951 persons arrived at fifty-seven airports of entry in the United States from foreign ports, requiring quarantine inspection. Of these, 2,456 airplanes were inspected and 23,899 persons were medically examined by medical officers of the Public Health Service. On April 6, 1934, the International Sanitary Convention for Aerial Navigation was signed on behalf of the United States by the American Minister at the Hague. This is an international agreement among twenty-three original signatory governments regulating airplane traffic in the interest of international health. The Surgeon-General says that with the greater use of aerial transportation and modern speed of travel, the time of passage from many countries to our shores now falls within the incubation period of many dangerous communicable diseases.

Travelers will be interested to know that the sources of drinking and culinary water used on interstate railroads, buses, vessels, and airplanes are inspected and certified by the United States Public Health Service. Ninety-four per cent of these supplies were inspected and certified during the year. It was found necessary to prohibit the use of twenty-eight of these supplies. Inspections were also made of shellfish-bearing areas to determine the efficacy of State control.

The Public Health Service covers a broad field in its research activities in the cause and prevention of disease. Its principal laboratory is the National Institute of Health in Washington, but it also maintains field laboratories in various parts of the country. The subjects of research include, among others, cancer encephalitis, heart disease, leprosy, malaria, psittacosis, Rocky Mountain spotted fever, tularemia, tick fever, child hygiene, dental conditions, industrial dermatoses, and milk sanitation.

At its Rocky Mountain spotted fever laboratory in Hamilton, Montana, the United States Public Health Service manufactured nearly 250 quarts of protective vaccine against Rocky Mountain spotted fever for the

1934 season. About forty quarts were used by the CCC for administration to personnel located in camps in the Northwest, where the danger of infection is greatest and the disease most frequently fatal. New areas of occurrence of this disease were found. . . .

The participation of the Public Health Service in the Civil Works program was an outstanding activity during the year. Through the use of work relief labor, assistance was given to fourteen States in malaria-control drainage work, in which 6,000 miles of ditching was carried out. In these States there are approximately two million cases of malaria each year, and the annual loss therefrom is estimated at half a billion dollars. Under the Civil Works program and aid, more than 225,000 sanitary outdoor toilets for rural homes were constructed in twenty-two States, the material being furnished by the home owners.

In the field of public health, new problems constantly arise and new dangers appear, such as those illustrated by the unusual type of encephalitis appearing in St. Louis in 1933, the extensive outbreak of amebic dysentery in Chicago, and the necessity for the control of distillery wastes which are now being emptied into already heavily overtaxed and polluted streams, thus seriously affecting the water supplies of the country. Constant vigilance is required for the early detection and study of these new, continually arising dangers to the public health in order successfully to combat them.

CORRESPONDENCE

Travel to American Medical Association.—The following information is transmitted to those of our members contemplating attendance at the American Medical Association meeting in Atlantic City the week of June 10. This will be an unusual meeting because it will be a joint one with the Canadian Medical Association. Members interested should contact the State Secretary, who will be pleased to arrange travel details.

January 7, 1935.

Dr. Frederick C. Warnshuis,
450 Sutter Street,
San Francisco, Calif.

Dear Doctor Warnshuis:

As the American Medical Association convention opens in Atlantic City on June 10, the delegates can leave San Francisco on our *Santa Rosa* May 17 (Los Angeles May 18), arrive New York June 4, and have six days at their disposal for visiting New York, Boston, Washington, Philadelphia, or Baltimore before the meeting opens.

The trip by our steamer is eighteen days from San Francisco and seventeen days from Los Angeles, stops being made in six foreign countries. Shore visits and excursions are available in each. Countries visited en route to New York are: Mexico, Guatemala, El Salvador, Panama, Colombia and Cuba, and stops are of ample time to permit passengers going ashore and taking the organized shore trips. No passports are necessary.

We operate three of the finest ships flying the American flag in this California-New York service. Every room is full outside and has its private bath or shower or both, with fresh water. The *Santa Rosa* and her sister ships have the largest outdoor tiled swimming pools on any ship, dining rooms on promenade deck amidships, a fine club and bar, gymnasium, Dorothy Gray beauty salons, and other attractive features.

The steamer fare to New York starts at $250 (room with private bath, of course) and rail fare back to California when bought with steamer tickets is $90 via any direct routing, through Chicago, St. Louis, etc. The cost per person for this water-rail trip around and across America (minimum priced accommodations aboard ship) may be arrived at as follows:

Steamer fare	$250.00
Rail fare home	90.00
Lower Pullman berth home	24.75
Dining car meals across continent not over	20.00
Total	$384.75

I attach hereto a detailed itinerary of the voyage indicated in second paragraph and shall be glad to furnish further information and assistance at any time.

Yours very truly,

R. V. CROWDER,
Passenger Traffic Manager.

Concerning SERA Fee Schedules:

Gonzales, California,
January 12, 1935.

Dr. Robert A. Peers,
Colfax, California.

Dear Doctor Peers:

This morning I sent the following letter to Doctor Clarence Toland:

"I am writing to you at the suggestion of the Monterey County Medical Society to ask if the State Society is taking action at this time to procure from the SERA a more acceptable fee schedule for medical services, especially as regards the hospitalization, laboratory and x-ray fees. We have noted in the A. M. A. Bulletin for November that in other states, notably Texas, Colorado, and Wyoming, in the West, the State societies have been instrumental in obtaining, and even in almost forcibly extracting acceptable fee schedules from the State or District Administrators of the relief organization. In Monterey County we have refused to accept the submitted fee schedule and panel system offered; but instead, have offered to accept a general panel system whereby all regular medical licentiates are on a general panel and the patient has a free choice of medical attendant, instead of being directed to a single panel man. The county society has offered to distribute the examination and report form blanks so that every physician will not need a supply, thus avoiding waste.

"We have agreed to accept the fee schedule temporarily except for the hospital, laboratory and x-ray fee schedule, which we have not accepted. No provision has been made for this work outside of the Monterey County Hospital. We hope that by refusing to be bound to an arbitrarily selected panel and ruinous fee schedule we will be in a better position to bargain for more equable status. Can we do anything to aid in gaining a more advantageous position for our profession? Please inform me if we can be of help."

As you are the president-elect of the State Medical Association, I am writing this with the hope that you will aid in furthering these proposals.

Yours very truly,

L. P. Davlin, M. D.,
President, Monterey County Medical Society.

January 15, 1935.

Dr. L. J. Davlin,
President, Monterey County Medical Society,
Gonzales, California.

My dear Dr. Davlin:

Your letter of January 12, with copy of the letter sent to Dr. Toland, regarding SERA fees, has just reached me and I thank you very much for keeping me posted as to what you are doing in the Monterey County Medical Society.

The Council of the California Medical Association has been aware of the necessity of securing arrangements with the SERA officials so that the interests of the medical profession, as well as the interests of the families on relief, shall be properly cared for. A committee from the Council has been in touch with SERA officials and has had numerous conferences with them. It seemed, as long ago as the first of December, that a satisfactory plan would be worked out, but there have been a number of delays, which have in no way been the fault of the members of the Council. The Council will meet next Saturday and we expect a report from the committee at that time.

I am sending a copy of this letter to Dr. Phillips, your district councilor. If you will get in touch with him, I am sure he can explain to you just what is being done and just how difficult it is to get definite arrangements with the SERA. However, I believe that everything will straighten out before long.

With very kind regards and wishing you success in your good efforts to protect the interest of the men in your society, I am Sincerely yours,

Robert A. Peers.

Note: All activities seeking to secure a state program for medical care for those on relief have been temporarily held up because of delay in appointing a new State Administrator. As soon as the appointment is announced prompt effort will be made to secure an agreement.—F. C. W.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 2, February, 1910

From Some Editorial Notes:

Annual Meeting.—The fortieth annual meeting of the Medical Society of the State of California will be held at Sacramento, April 19, 20, and 21, 1910, under the administration of Dr. James H. Parkinson of Sacramento, president. . . .

* * *

Dr. Arberry Convicted.—The San Francisco County Medical Society and its attorney, Mr. Walter Kaufman, have indeed won a signal victory for decency and honesty in medicine by the conviction of one Dr. John J. Arberry of the crime of attempting to obtain money by false pretense, which verdict was secured after months of hard work, on January 13, 1909. . . . It is the first case of the kind in which a verdict of this sort has been secured in the United States, and it marks an epoch in the war of honesty and legitimate medical science against those dishonest and disreputable members of the profession they disgrace who follow the practices of the advertising quack.

* * *

Sanitary Needs.—Of recent years a new field has been opened for properly equipped physicians which has not received the attention from our medical schools that it deserves. Dr. William F. Snow, a thoroughly trained sanitarian, and the secretary of the State Board of Health, says that there are few men available who possess the necessary education in preventive medicine to make them efficient officers of the public health. . . .

* * *

Prosecution of Quacks.—This whole question of the prosecution of illegal practitioners and of those who are licensed but are nevertheless following dishonest quackery, is a very large and a very important one. . . .

* * *

Tuberculosis Ordinance.—Probably no more significant legislation has been enacted in San Francisco during the past year than the ordinance relative to the prevention of the spread of tuberculosis, which recently became a law. . . .

* * *

Outrageous Treatment.—In two towns in our State most iniquitous action has been taken by the Town Trustees. At St. Helena and at Salinas, ordinances have been passed requiring a license of $12 per year to practice medicine. . . .

From an article on "Importance of the Eye, Ear, Nose, and Throat Examinations in the Railway Service" by A. C. Seely, M.D., Roseburg, Oregon.

This is rather a long title, but I promise you a very short paper. This subject was selected because I feel convinced that the examination of the eye and ear beyond vision and audition receives too little attention, and the nose and throat none at all. . . .

From an article on "Amebiasis" by J. D. Long, Past Assistant Surgeon, United States Public Health and Marine Hospital Service.

Since December 1, 1908, I have seen in the Marine Hospital and in the city of San Francisco 114 cases of amebiasis.

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, page 14)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

In the 1934 annual report of the Board of Medical Examiners recently submitted to Governor Merriam, comment is made on various impostors who have attempted to secure a California license on false claims of medical credentials. Two of them were reported by the Criminal Identification Bureau as having quite a record.

Mention is made of the arrest in Kansas City, Missouri, of William T. Gallagher and George M. Lindsay for violation of the federal postal laws, based on an asserted "diploma mill," which is said to have supplied medical and chiropractic diplomas for a specified price and to have involved one or two states in a claim that licenses to practice could be obtained on the "goods" furnished by this mill.

Regulation of the too prevalent broadcasting of worthless medical advice and claims for asserted curative value of proprietary drugs is urged, reference being made to specific cases.

Five revoked medical certificates were restored during the year.

Examination records show that 324 physicians and surgeons took the written examination, 92 per cent having passed and 7 per cent having failed. The larger percentage of failures came from foreign medical schools. Germany, Russia, Italy, Philippine Islands, and Canada all furnished applicants, the larger percentage, *i. e.,* eleven, being from German medical schools.

Ninety-nine reciprocity applicants were granted licenses, the larger number being based upon Illinois medical licenses. Fifty-seven licentiates of California sought registration by reciprocity in other states.

Thirty licentiates were called before the Board on charges of unprofessional conduct, the larger number, ten, being based on narcotic derelictions. Fifteen licenses were revoked; thirteen were placed on probation, and two hearings were pending for disposition in 1935.

A voluminous report of the Investigation Department, North and South, tabulated the activities in law enforcement.

Licentiates in the number of 249 died during the past year, special mention being made in the annual report of former Board members—Dr. P. T. Phillips, Dr. H. Miller Robertson, and Dr. H. A. L. Ryfkogel.

Nine licentiates filed documentary evidence re change of name, and Board records were adjusted in accordance therewith.

Reports relate Mrs. H. J. Smith on or about January 11, 1935, pleaded guilty in the courts of San Diego to a charge of violation of the Medical Practice Act and was sentenced to serve ninety days in the county jail, sentence suspended on condition of no further violation.

On December 7, 1934, Augusto Monasterio is reported to have paid in the courts of Los Angeles a fine of $100, based on a charge of violation of the Medical Practice Act.

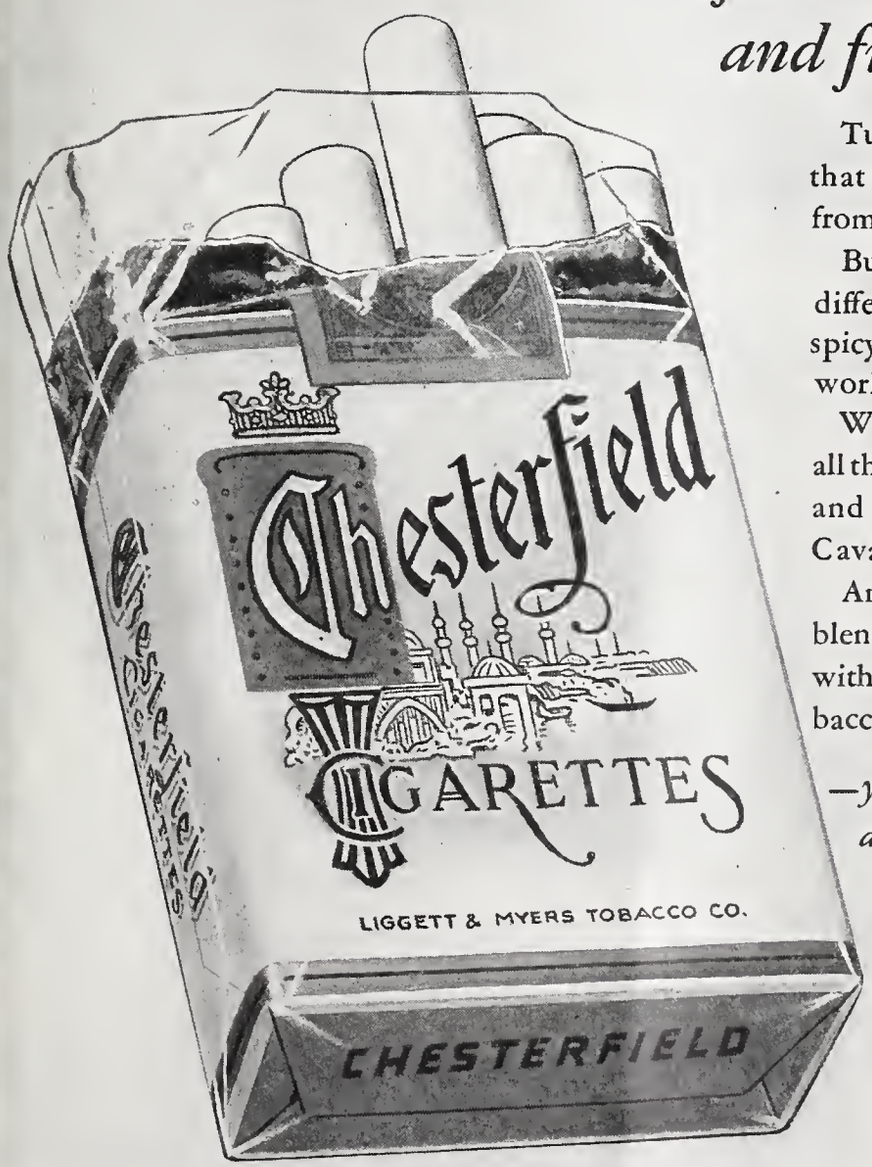
B. H. Duncan, reported as the bogus Lord Conyngham, Earl of Camperdown, etc., charged with violation of the Medical Practice Act, was on January 9,

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, page 15)



—for that better taste and fragrant aroma



Turkish tobacco leaf is so tiny that each of these bales contains from 70 to 80 thousand leaves.

But there's another and greater difference—Turkish is the most spicy and aromatic tobacco in the world.

We have Chesterfield buyers in all the tobacco markets of Turkey and Greece, including Xanthi, Cavalla, Smyrna and Samsoun.

And when you blend and cross-blend aromatic Turkish tobacco with mild ripe home-grown tobaccos as we do in Chesterfield

—you have a milder cigarette, a better-tasting cigarette.

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FRENCH HOSPITAL • Geary Street and Fifth Avenue SAN FRANCISCO, CALIFORNIA

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V. LABRUCHERIE, *Superintendent*
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A general hospital of 225 beds operating an accredited school of nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and is operated by the French Mutual Benevolent Society, through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons

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DAVID A. WOOD, M. D., Director of Laboratory

Many Caustic Poisons Inadequately Labeled.—A survey by the Baltimore station, Federal Food and Drug Administration, of poisonous chemical compounds, including lye, carbolic acid, and oxalic acid, sold by dealers in the District of Columbia, indicates that a material proportion of these substances now on sale do not comply with the provisions of the Federal Caustic Poison Act, according to W. G. Campbell, Chief of the Food and Drug Administration. Results of this survey, said Mr. Campbell, logically suggest that many retail dealers in other cities are selling caustic or corrosive substances without labels showing their dangerous character.

Retail dealers in many cities buy such products as carbolic acid, oxalic acid, hydrochloric acid, and silver nitrate in bulk, and deal the products out at retail in small quantities. The health interests of the public, Mr. Campbell said, demand that before such sales are made the poisons be clearly labeled as to their dangerous character.

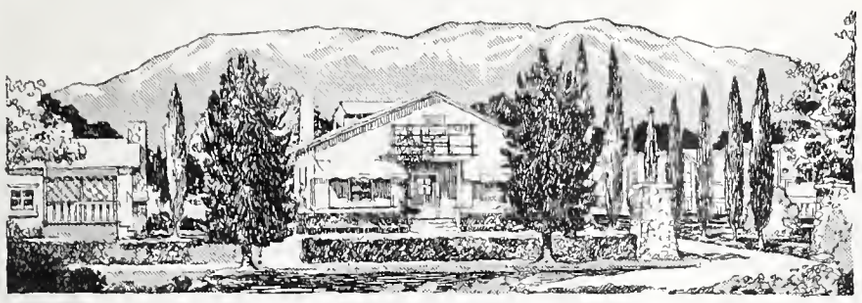
The two important requirements of the Federal Act are placing the word "poison" on the label in letters of a specified size and style, and a statement of antidotal treatments in case of accidental personal injury. The caustic poisons and the preparations containing them in the specified concentrations, which by law must be labeled, are: silver nitrate, carbolic, oxalic, hydrochloric, sulphuric, nitric, acetic, and hypochlorous acids, and ammonium, sodium, and potassium hydroxids. Many of these substances are commonly used in the household for cleaning, disinfecting, or other purposes. All of them are potentially injurious to the body if not carefully employed.

Early this year inspectors of the Food and Drug Administration visited druggists, paint dealers, and other retailers in the District of Columbia and informed them as to the labeling requirements of the Federal Caustic Poison Act with respect to labeling the chemicals which come within the law, Mr. Campbell stated. Later, in order to determine the effect of this educational effort, official samples of caustic poisons were obtained from eight-five dealers. Examination of these samples showed that fifty-eight of them were either not labeled in compliance with the Caustic Poison Act or carried no labels at all. A large proportion of the carbolic acid samples were not labeled to comply with the requirements of the Federal Food and drugs, Insecticide, and Caustic Poison Acts. Carbolic acid and many other caustic substances are virulent poisons. Routine preliminary hearings, required under the federal laws, are now being held in Washington to permit druggists and other dealers to show cause why their cases should not be referred to the Department of Justice for prosecution.

Mr. Campbell pointed out that at this stage in the proceedings he has no authority to mention the names of those who may be prosecuted for violations of the Caustic Poison Act and other laws involved, but that he anticipates that the survey will lead to legal actions against some of the dealers. The Caustic Poison Act grants federal officials no authority over intrastate shipments of caustic poisons, nor does it require that caustic poisons shipped in bulk be labeled with the word "Poison," and the antidote. The law, however, does authorize the Administration to control sales of caustic poisons within the District of Columbia and within the territories of the United States.

Summary of Mortality from Automobile Accidents.* The United States Bureau of the Census announces that during the four weeks ending February 17, 1934, eighty-six large cities in the United States reported 664 deaths from automobile accidents. This number (664) compares with 548 deaths during the four weeks

* United States Department of Commerce, Bureau of Census, Division of Vital Statistics, bulletin of March 1, 1934.



SOUTHERN SIERRAS SANATORIUM

C. E. ATKINSON, M. D. *Medical Director*

SOUTHERN SIERRAS SANATORIUM
BANNING, CALIFORNIA

For Tuberculosis and Allied Affections

Has established and maintained a reputation, both among physicians and patients, for service and satisfaction.

Doctor: Send your next patient here, and you may feel assured not only that he will receive maximum benefit from his sojourn, but he will be grateful and will thank you for sending him to

SOUTHERN SIERRAS SANATORIUM

TWIN PINES SANITARIUM
BELMONT, CALIFORNIA
INTERNAL MEDICINE AND SELECTED NEUROPSYCHIATRIC CASES
CLARE MEHRTENS, *Director* **WILL REBEC, M. D., *Medical Director***

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ending February 18, 1933. Most of these deaths were the result of accidents which occurred within the corporate limits of the city, although some accidents occurred outside of the city limits.

For comparison, the number of deaths due to automobile accidents within city limits is desirable. Such figures are available for the four-week period ending February 17, 1934, and for the corresponding four-week period of 1933 for all of the eighty-six cities, the four-week figure in 1934 being 534 as contrasted with 439 for the corresponding four weeks in 1933.

Considering by four-week periods since January, 1930, total deaths from automobile accidents, whether within the city limits or outside, the lowest total (513) appears for the four-week period ending April 15, 1933, and the highest (877) for the four-week period ending January 23, 1932.

TOTAL NUMBER OF DEATHS REPORTED BY EIGHTY-SIX CITIES
Four weeks ending:

February 17, 1934	664	January 23, 1932	877
January 20, 1934	814	December 26, 1931	781
December 23, 1933	789	November 28, 1931	828
November 25, 1933	734	October 31, 1931	730
October 28, 1933	751	October 3, 1931	732
September 30, 1933	708	September 5, 1931	665
September 2, 1933	640	August 8, 1931	684
August 5, 1933	601	July 11, 1931	695
July 8, 1933	570	June 13, 1931	648
June 10, 1933	543	May 16, 1931	690
May 13, 1933	534	April 18, 1931	680
April 15, 1933	513	March 21, 1931	611
March 18, 1933	546	February 21, 1931	627
February 18, 1933	548	January 24, 1931	749
January 21, 1933	735	December 27, 1930	837
December 24, 1932	654	November 29, 1930	824
November 26, 1932	730	November 1, 1930	760
October 29, 1932	683	October 4, 1930	765
October 1, 1932	651	September 6, 1930	685
September 3, 1932	572	August 8, 1930	646
August 6, 1932	515	July 12, 1930	677
July 9, 1932	522	June 14, 1930	680
June 11, 1932	549	May 17, 1930	622
May 14, 1932	568	April 19, 1930	639
April 16, 1932	560	March 22, 1930	595
March 19, 1932	515	February 22, 1930	583
February 20, 1932	605	January 25, 1930	671

For the fifty-two week periods, February 17, 1934, and February 18, 1933, the totals for all the cities were, respectively, 8,406 and 7,802, which indicate a recent rate of 22.5 per 100,000 population as against an earlier rate of 20.9 or an increase of 8 per cent in the rate during the year.

Eleven cities reported no deaths from automobile accidents for the last four weeks, while nine cities reported no deaths from automobile accidents for the corresponding period of 1933.

For the last four-week period reports as to whether deaths occurred from automobile accidents within city limits or outside were received from all of the eighty-six cities reporting. In these cities in this four-week period, the total number of deaths from automobile accidents was 664, but only 534 of these were due to accidents within city limits.

Low Death Rate for Typhoid.—The 1932 typhoid mortality rates for twenty-eight states are available. There are only six of these states that have lower typhoid death rates than California. They are Connecticut, Minnesota, New Jersey, Wisconsin, New York and Michigan. In consideration of the fact that most California public water supplies come from surface streams, it is remarkable that California communities are able to maintain a state typhoid death rate that compares favorably with similar rates for other states. Through safeguarding water supplies properly, the people of California are insured against many cases of devastating illness and possible death. It is not many years ago that the average community expected to have a certain number of typhoid cases present each year. Today typhoid never occurs in some communities of the state and it is a fact that many physicians never have the opportunity to see a case of this disease.

Following are the death rates from typhoid fever in 1932 for twenty-eight states:

Connecticut	.6	Indiana	2.5
Minnesota	.7	Montana	2.8
New Jersey	.7	Maryland	3.0
Wisconsin	.7	Idaho	3.3
New York	1.0	Alabama	4.9
Michigan	1.1	North Carolina	5.0
California	1.3	Virginia	5.1
District of Columbia	1.4	Mississippi	6.3
Nebraska	1.4	Louisiana	10.8
South Dakota	1.4	Tennessee	11.0
Illinois	1.7	West Virginia	12.1
Iowa	1.7	Georgia	12.6
Kansas	1.7	South Carolina	14.7
Pennsylvania	1.8		
Ohio	2.0	*Average for 28 states*	3.2

CALSO WATER

Palatable ALKALINE *Sparkling*

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Diphtheria Not Necessary.—Sixty-three years ago John Ruskin wrote: "Let a child fall into the river before the roughest man's eyes;—he will usually do what he can to get it out, even at some risk to himself; and all the town will triumph in the saving of one little life. Let the same man be shown that hundreds of little children are dying of fever for want of some sanitary measure which will cost him trouble to urge, and he will make no effort; and probably all the town would resist him if he did."

Less than fifty years ago diphtheria was the most dreaded scourge of childhood; it killed half the children attacked. The physician could do nothing except endeavor to relieve the intensity of the little patient's suffering and helplessly watch him struggle painfully through to recovery or sink to an untimely death.

Then came the discovery of diphtheria's cause, its chief methods of transmission and, finally, antitoxin, one of the most potent weapons of modern medical science. Diphtheria could be cured; many thousands of little lives were saved annually, but the number of cases of the disease continued almost undiminished and it still reaped an alarming harvest of death. Most of these deaths could undoubtedly be traced to the insidiousness of the attack having deceived parents as to its nature, and so when a suspicion arose or serious symptoms occurred and the physician was called, the case was hopeless.

Thus it was soon learned that antitoxin must be used early and generously and that through no fault of the remedy or of the physician, deaths from diphtheria must be expected so long as there are diphtheria cases.

Then came the wonderful announcement that there need be no diphtheria *cases*; a simple method had been discovered by which any child could be made immune.

Accidents Claim Many Lives in California.—There were 5,059 accidental deaths in California in 1932. Of these, 3,684 were in men and 1,375 were in women. Almost half of all accidental deaths in the state last year were in motor vehicle accidents and nearly one-quarter of the total number were due to accidents in



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the home. There were 1,126 public accidents not due to motor vehicles. This includes railroads, street cars, water and air transportation, falls, drowning, firearms, and other related causes. There were but 361 industrial accidents. The comparatively small number of industrial accidents indicates the remarkable progress that has been made through the provision of safety regulations and their enforcement in the industries.

Industrial Deaths.—Of the 361 deaths in the industries, there were but three among women and 358 among men. Agriculture, construction, transportation, trade, mining and quarrying claim most of these industrial lives. The industrial deaths are analyzed as follows:

Agriculture	67
Construction	53
Transportation and public utilities	47
Trade	41
Mining and quarrying	39
Other extractive industries	20
Manufacturing	20
Clerical and professional	8
Other occupational accidents	66

Accidents in the Home.—Of the 1,225 accidents in the home, 650 were in women and 575 in men. More than half of these deaths were due to falls. More than 20 per cent were due to burns, scalds, and explosives. More than 10 per cent were due to asphyxiation and suffocation; more than 8 per cent to poisons, and 3½ per cent to firearms. The deaths from accidents in the home may be segregated as follows:

Falls	624
Burns, scalds, and explosions	250
Asphyxiation and suffocation	28
Poisons	99
Firearms	43
Other home accidents	81

Nearly half of all deaths from home accidents were in individuals more than sixty-five years of age and most of these were due to falls. Unofficial records

(Continued on Next Page)

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(Continued from Preceding Page)

indicate that most of these falls occur on stairs and steps. Since most of them occur in elderly persons, it appears that special safeguards would be needed to prevent such deaths. Very few individuals under forty-five years of age meet with fatal accidents due to falls in the home. On the other hand, most deaths from burns and most deaths from asphyxiation and suffocation occur in children who are under fifteen years of age. The greatest number of accidental deaths due to firearms occurs in children between the ages of five and fourteen, and most deaths from all accidental causes occur in children from one to four years of age. There is significance in the fact that 18.3 per cent of all fatal home accidents occurred last year in children who were under fifteen years of age. Burns and scalds are also fatal to persons of advanced age. It would appear that more efficient safeguards in the prevention of accidental deaths from firearms, poison, burns, asphyxiation and suffocation are needed for children under fifteen years of age. All of these deaths may be classed as preventable, and it is unfortunate that so many children's lives should be sacrificed needlessly to these preventable causes.

Motor Vehicle Deaths.—This is the most important among all accidental deaths. The lot of the pedestrian in motor vehicle deaths is hazardous, as most deaths in this group occurred in collisions of motor vehicles with pedestrians. There were 823 such deaths last year, as compared with 658 deaths which occurred in collisions between motor vehicles. Collisions of motor vehicles with railroad trains took 77 lives, with electric cars 58, with bicycles 31, with horse-drawn vehicles 3, and collision with fixed objects claimed 129 lives. The third most important cause in motor vehicle deaths were deaths that were not due to collisions, 568 lives having been taken in motor vehicle accidents due to overturning, running into ditches, and other causes related to speeding and loss of control of vehicles. Out of the total of 2,347 motor vehicle deaths last year, 1,783 were in men and 564 in women.

The greatest number of deaths in motor vehicle accidents occurred among individuals between the ages of fifteen and twenty-four. These deaths occurred in collisions with other motor vehicles and in noncollision accidents. On the other hand, most of the individuals who lost their lives in collisions of motor vehicles with pedestrians were persons more than sixty-five years of age. Two hundred seventy-nine such individuals lost their lives last year in such collisions.

It would appear, then, that elderly pedestrians as a group constitute the greatest hazard in motor vehicle deaths. The next greatest hazard in such deaths is in the age groups from fifteen to thirty-four, most of which deaths occur in collisions between motor vehicles and in noncollision accidents. There is further significance in the fact that more than half of all motor vehicle deaths last year (1,210) were in individuals who were gainfully employed.

Public Accidents.— Drowning is important among public accidents, as 338 individuals lost their lives through drowning last year. Next in importance is falls in public places, 218 individuals having lost their lives in such accidents last year. The numbers of deaths in 1932 in other public accidents are as follows:

Railroad	102
Air transportation	72
Water transportation	67
Street car	64
Other vehicles	9
Firearms	56
Burns, scalds, and explosions	25

Among public accidents due to falls, individuals more than sixty-five years of age again present the greatest hazard. There were seventy-four deaths due to this cause among such individuals last year. Street-car accidents also claimed a large number of deaths among individuals who are more than sixty-five years

of age. Most deaths from drowning, on the other hand, occur among individuals who are under twenty-five years of age. There were 145 such deaths last year. A considerable number of deaths from drowning also occurred among individuals between the ages of forty five and fifty-four, 64 such deaths having occurred last year. It would appear, then, that most deaths from drowning occur among young adults who take extreme hazards and among middle-aged individuals who probably overestimate their ability to withstand the hazards incidental to swimming. Most deaths from accidents due to firearms occurred among individuals between fifteen and thirty-four years of age.

An analysis of accidental deaths in California in 1932 indicates clearly that motor vehicles are responsible for most accidental deaths that occur. Falls in the home constitute the next chief factor in the production of accidental deaths, and drowning is third in importance among such deaths, followed by burns, scalds and explosions, and falls in public places. While it is true that nearly 25 per cent of all accidental deaths are among individuals past sixty-five years of age, the greatest numbers of such deaths occur among individuals who are in the prime of life. The continuance of safety campaigns and the adoption and enforcement of regulations in the prevention of accidental deaths would seem to be of first importance in the prevention of needless mortality due to these preventable causes.

Study of Medicine Strenuous Course.—The University of California Clip Sheet prints the following: What does it mean to study medicine? At the University of California it means eight years of continuous study after the completion of a high school course.

In the bulletin of general information for the University Medical School just issued it is pointed out that students expecting to enter medicine must complete a three-year premedical course including such required subjects as English, American Institutions, chemistry, foreign languages, physics, zoölogy, and military or naval science.

Following this training, the student applies for admission to the medical school proper. Of the several hundred applications usually received, the best sixty-four are accepted. If the student is fortunate enough to be among these sixty-four he enters upon a five-year course of training, the first four in classroom work and the last as an interne or laboratory assistant.

During the first four years the student must complete 4,304 hours of satisfactory study in eighteen required subjects. These subjects are: anatomy, physiology, biochemistry, bacteriology, pathology, preventive medicine and public health, pharmacology, general medicine, neuropsychiatry, dermatology, legal medicine, medical history, pediatrics, surgery, orthopedic surgery, ophthalmology, otology, rhinology and laryngology, and obstetrics and gynecology.

At any time the student may be dismissed for mental, physical or moral unfitness for a career of medicine. Tuition and other fees for the five-year medical course total about $800 for a resident of the state, and about $1,300 for a non-resident. In addition, the student must purchase a microscope, a blood-counting apparatus, and an ophthalmoscope.

The kernel of the scientific outlook is a thing so simple, so obvious, so seemingly trivial, that the mention of it may almost excite derision.

The kernel of the scientific outlook is the refusal to regard our own desires, tastes and interests as affording a key to the understanding of the world.

Stated thus baldly, this may seem no more than a trite truism. But to remember it consistently in matters arousing our passionate partisanship is by no means easy, especially where the available evidence is uncertain and inconclusive.—Bertrand Russell.



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5. Colfax is accessible. It is on the main line of the Ogden Route of the Southern Pacific R. R. and has excellent train service. It can be reached by paved highway, being on the Victory Highway, with paved roads all the way to Colfax.

For further information address

ROBERT A. PEERS, M. D., *Medical Director*
Colfax, California

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American Medical Association, Atlantic City, New Jersey, June 10-14, 1935

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Many Food and Drug Seizures.—Late returns have added two thousand bushels of apples bearing spray residues in amounts dangerous to health, to the previously reported November total of sixteen thousand bushels seized. Apple inspections in December resulted in the seizure of 4,300 bushels. During November and December, a period of heavy seasonal movement of apples, nearly ten million bushels, which were satisfactory from the spray residues standpoint, moved in interstate commerce. One lot of dried apple chops was confiscated for a similar violation, as were ninety crates of broccoli. Two lots of a "digestible cocoa compound" which analysis showed contained a dangerous amount of lead, were seized at Jersey City. One hundred and seventy-three jars of pickles sweetened with saccharin were seized in Topeka, Kan. The pickles had been shipped by a manufacturer in St. Louis, Mo.

Salad oils continue to figure prominently in reports of legal action, because some packers are still reluctant to remove the misleading designs, Italian verbiage, flags and olive branches from the labels of their products, which commonly are composed of sunflower seed oil, cottonseed oil, corn oil, and sometimes a small percentage of actual olive oil for flavor. Seventeen shipments of misbranded oils were seized during December, the Administration reports. Two lots of high-proof cider sold as champagne and labeled "champyne" were seized in Washington, D. C. Work under the canned-food amendment to the Food and Drugs Act resulted in the confiscation of one lot of substandard canned cherries and three of substandard canned peas.

The following commodities were seized during December because of dirt, insect infestation, decomposition, or mold: twelve shipments of tomato puree, catsup, and paste; 550 cans of frozen eggs; 360 sacks of potatoes; eight lots of canned shrimp from Mississippi, Alabama and Florida, and one lot of three thousand pounds of frozen shrimp from Texas; four consignments of canned California mackerel, two of Italian chestnuts, and one of walnuts; ripe olives, cold-pack strawberries, figs, canned huckleberries and peaches.

Seizure actions were initiated against the following medicinal products because of false and fraudulent therapeutic claims on their labels: "Rosenberg's Improved Great Century Oil" shipped from Lititz, Pa., labeled as a treatment for rheumatic pains, neuralgia, sore throat, lame back, horse colic and cramps; "Garlic Tablets" manufactured in New York City, bearing claims of vitamin A, B and C potency, and efficacy in high blood pressure, rheumatism, arthritis, poor circulation, asthma, kidney trouble, diphtheria, tuberculosis, and parasitic worms; "Cozzins New Formula for Asthma" shipped from Brooklyn, N. Y., and "Calafo Liquid" from Los Angeles, Calif., both represented as treatments for asthma and hay fever; "Dr. Duhaime's Red Cross Pills" made at Fall River, Mass., and offered for anemia, kidney and bladder troubles, indigestion, and blood impurities; "Grainalfa" and "Glandictine" originating in Los Angeles, sold under claims of benefit in glandular disorders, and in mineral and vitamin deficiencies; "Edgerton's Medicated Stock Salt Brick," Atlanta, Ga., for disorders of livestock; and "Elixir Ampirin," Oxford, N. C., a purported treatment for grippe, nervousness, loss of sleep, physical and nervous strain. In the case of the last product named, the content of acetanilid and alcohol did not tally with the quantities found by Government chemists.

Other drug products involved in seizure proceedings were substandard tinctures and fluidextracts of aconite, digitalis and squill, seized at New Orleans; crude cascara bark containing excessive rock, dirt, moldy bark and other impurities; and "Compound Epsom Salt Tablets" mislabeled as to composition. . . .

New and Better Tuberculin Aids Cattle-Health Campaign.—A new tuberculin, free from foreign protein, has been in use since last April in the testing of cattle for tuberculosis, the United States Department of Agriculture reports. The new product is materially superior to the tuberculin formerly available. Officials point out that the improvement came at a particularly fortunate time, since tuberculin testing has been increased as an emergency and drought relief activity, and more cattle have been tested in the last eight months while the new tuberculin has been available than in any previous similar period of the campaign. Dr. M. Dorset of the Bureau of Animal Industry says that enough of the new tuberculin is being produced to test more than 18,000,000 cattle annually. . . .

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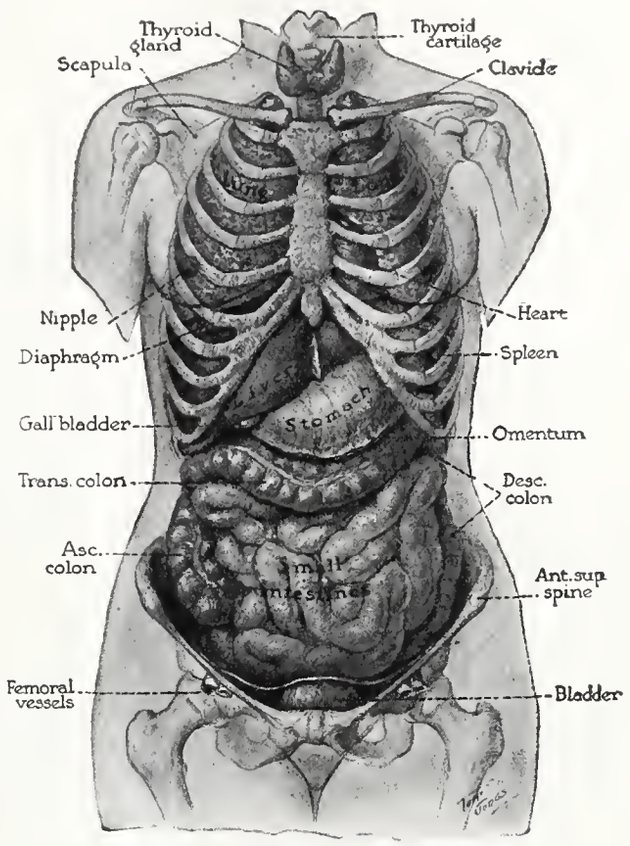
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of this nature within bounds, it is felt, nevertheless, that a somewhat fuller discussion of the contributions from experimental embryology would serve to enrich the text and direct the student along a more widening pathway. The reviewer feels, likewise, that from the point of view of the physician those regions which present frequent problems of great practical importance might be less sketchily presented; for example, the section dealing with the branchial clefts. These defects are no doubt covered to a certain extent by the excellent bibliographical details which follow each chapter.

The reviewer has no doubt that this work will continue to earn its merited popularity as a well-balanced text on elementary embryology. The clear type, the excellent illustrations and the pleasing format are typical of that general high standard which we have come to associate with the name of this publishing firm.

J. B. deC. M. S.

Recent Advances in Neurology. By W. Russell Brain and E. B. Strauss. Third edltion. Pp. 442. Illustrated. Philadelphia: P. Blakiston's Son & Co., Inc. 1934. Price, $5.

This book follows, after four years, the second edition of 1930.

Chapters found in the third edition not found in the second are: one on Injuries of the Brain, one on the Plantar Reflexes and the Grasp Reactions, one on Micturition and Its Disorders as a Result of Lesions of the Nervous System, one on General Paralysis, and one on Disseminated Sclerosis.

A volume that belongs in every neuropsychiatrist's library. E. W. T.

Pathologie und Klinik der Granulosazelltumoren. By Walter Schiller. Pp. 197. Illustrated. Wien: Verlag von Wilheim Maudrich. 1934.

This is a monograph of interest only to a limited group. It gives a complete summary of the present knowledge of this interesting group of tumors, with an extensive bibliography. The author accepts Fischel's theory of the origin of the normal granulosa from the embryonic ovarian menechyme and believes that the granulosa cell tumors arise from dormant rests of this mesenchyme rather than from the more fully differentiated "granulosa-cell balls" of Robert Meyer. He discusses exhaustively both pathologic and clinical features as well as some not too convincing experiments upon the artificial production of this tumor in animals. He feels that the generally accepted idea that these tumors are histologically malignant but clinically benign means merely that the histologic criteria for malignancy are wrong and establishes his own criteria which have been borne out by the clinical course in all cases. The text is somewhat redundant and written in more than usually ponderous German, but covers the subject completely and would be of interest to anyone making a study of these tumors. M. S.

Wish-Hunting in the Unconscious—An Analysis of Psychoanalysis. By Milton Harrington. Pp. 189. New York: The Macmillan Company. 1934. Price, $2.50.

A vade mecum for the contra-Freudian. Not so complete as The House that Freud by Jastrow, and lacking the burlesque element which characterized Wohlgemuth's "Critical Examination," both of which authors are quoted, but still a fairly good presentation of the views of those who do not accept the Freudian ideas, but it will not make renegades out of the faithful. E. W. T.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 216)

Medical Machines.—One hears, from time to time, more or less talk about "machines" that run medical societies, and the comment is always derogatory—or worse. What does it all mean? It simply means that those who have not the energy, the ability, the time or the inclination to do a certain amount of work, object when they see others doing it. . . .

From an article on "The Uses of Bacterial Vaccines in Urinary Disease" by Granville MacGowan, Los Angeles.*

Out of the labors of many men whose lives have been given up to the investigation of the wonders, greater than any fairy tale ever told, of serum therapy, has grown the marvelous and miraculous application of the principles of bacterial vaccines. . . .

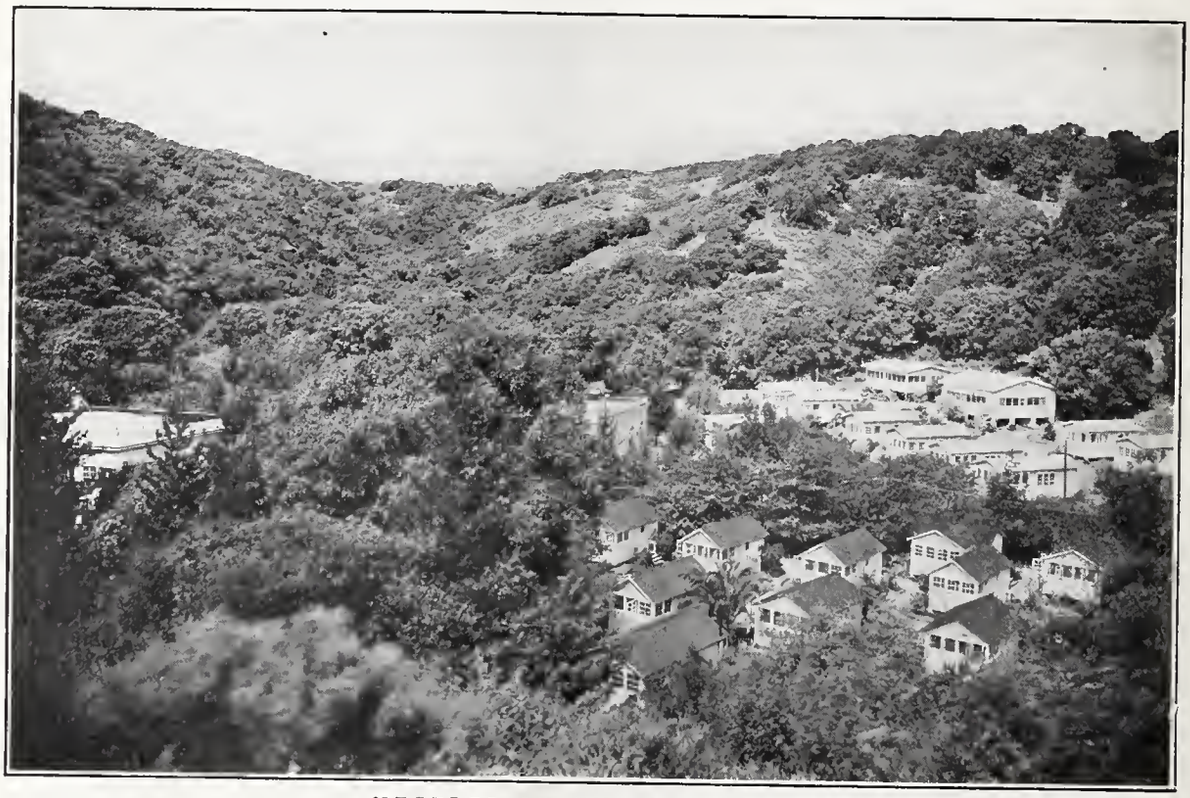
* Died on January 31, 1935.

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

From an article on "Surgical Shock" by David Powell, M. D., Marysville.

"Crushing injuries of the extremities caused by railway accidents and machinery, furnish the largest percentage of grave cases of shock" (Senn). Surgical shock is often the most important symptom of general injury involving the nervous system and vital organs of the body, and also parts not essential to life. Indeed, in all serious railway injuries, the most urgent condition that demands attention, after the arrest of hemorrhage and the relief of pain, is shock—"a sudden depression," as Bailey defines it, "of the functional activity of the general nervous system." . . .

From an article on "The Value of the Cerebrospinal Fluid Examinations in the Diagnosis of Chronic Nervous Disease" by H. C. Moffit, M. D.

The value of lumbar puncture in the diagnosis of certain acute nervous diseases, of meningitis, of ventricular or traumatic cerebral hemorrhage, needs no emphasis. The work of Ravaut, Sicard, Nageotte, Widal, and more lately of Erb and Nonne, has shown the importance of lymphocytosis in the spinal fluid. . . .

From an article on "Congenital Dislocation of the Hip" by Harry M. Sherman, M. D., and George J. McChesney, M. D., San Francisco.

At the meeting of this Society held in Fresno I reported the first of the cases of congenital dislocation of the hip that I had attempted to correct. The report was but a preliminary one and covered several cases in which the reduction had been accomplished through an incision with deepening of the acetabulum according to the earlier technique of Lorenz, and also a smaller number of cases in which the reduction had been attempted by the manipulative method of Lorenz, as it was then practiced. . . .

From an article on "Alkaptonuria" by John C. Spencer, M. D., San Francisco.

My excuse for occupying your attention with the subject of alkaptonuria, is the rarity of the condition—there having been but fifty cases recorded in medical literature—and the fact that one examining urine more or less frequently may stumble across a case and be somewhat at a loss to explain the phenomena characteristic of the condition. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 216)

"The Chiropractice League of California will carry to the State Supreme Court its fight to prevent chiropractors from practicing 'the principles of medicine,' it was announced today by Dr. James Workman of Santa Ana, vice-president of the state organization. . . . 'The Appellate Court,' Doctor Workman pointed out, 'decided the case on a technicality and did not rule on the principles involved. We expect the Supreme Court definitely to rule on the principles.' Said Doctor Workman: 'These chiropractors have been going far beyond and using various modes as a curing method.' The test was based upon the ground that said practice of the principles of medicine was a nuisance in the sense that chiropractors were practicing the principles of medicine. . . ." (Santa Ana *Register*, February 2, 1935.)

(Continued on Page 20)



The "Continental" Breakfast is not suitable for a growing child

In far too many homes, a breakfast of a roll and a cup of coffee is the fare for children as well as adults. Woefully deficient in vitamins and minerals, such a meal furnishes little more than a small amount of calories. A dish of Pablum and milk, however, is just as easily prepared as a "continental breakfast," but furnishes a variety of minerals (calcium, phosphorus, iron, and copper) and vitamins (A, B, G, and E) not found so abundantly in any other cereal or breadstuff.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 18)

"Chiropractors would be permitted to examine and treat injured persons seeking compensation under the Workmen's Compensation Insurance Safety Act by the terms of a bill introduced yesterday by Assemblyman Fred Reaves of Los Angeles County. At present the treatment can be given only by a physician." (Sacramento *Bee,* January 22, 1935.)

Frank Woodville Bogard, alias C. C. Cabot, featured in the 1934 annual report of the Board of Medical Examiners, on February 1, 1935 entered a plea of guilty in the police court of Fresno to a charge of violation of the Medical Practice Act and was sentenced to sixty days in the county jail. At the time of his arrest there was found in his possession one of the cards which the Board of Medical Examiners requires to be filled in by reciprocity applicants. On this he had entered his name, statement that he was a graduate of the University of California in 1917, had done postgraduate work in Paris, was in general practice, was "a specialist in the State of California," and a "Toxicologist Supreme Sixth Hemisphere."

Our Los Angeles investigation department reports a recent "Claim and Delivery Action filed by Byron H. Pelton, M. D., through his attorney, Mr. John S. Cooper," to recover Doctor Pelton's cards, letters or papers, his United States Government (narcotic) order books and eight large and four small bottles containing narcotics, he valuing the same at $500. In this connection he also asks damages in the amount of $1,000 for failure to return the same. All these articles were reported seized by the State narcotic officers as evidence at the time Byron H. Pelton, M. D., was arrested by them on an asserted charge of violation of the State narcotic law and probably will be part of the evidence used in the charges now pending against Doctor Pelton before the Board of Medical Examiners.

"Assertedly operating a cancer clinic, where they diagnosed cases and treated patients without possessing a State license, two Oakland men were arrested by police at 1411 High Street, East Oakland, last night. Held for investigation, pending charges of unlawful practice, are William F. Hoque, sixty-three, and his son, Herbert V. Hoque, thirty-two, both of San Jose. On complaint of Mrs. Ethel Cardoza, twenty-six, 2206 Eighty-third Avenue, Oakland, police and Deputy District Attorney Owen Holte raided the Hoque Cancer Foundation at the High Street address and seized the two men, confiscating a large assortment of medical implements and apparatus. Father and son are held at the Oakland city jail in default of $1,000 bail." (San Francisco *Chronicle,* January 20, 1935.) (Previous entries, May, June, and July, 1929.)

"Another prosecution for alleged violation of the Medical Practice Act was launched today when M. C. Hin, operator of an herb establishment at 1403 Tulare Street, was taken into custody upon a complaint signed by J. W. Davidson, inspector for the State Medical Board. Hin and Woodville Bogard, who allegedly represented himself as a bacteriologist, were arrested following investigations by Davidson, the latter being taken into custody yesterday. . . . Bogard, who served terms in San Quentin and Folsom on check charges, is under $1,000 bond, and Hin's bond is set at $250. . . ." (Press dispatch dated Fresno, January 19, and printed in the San Francisco *Chronicle,* January 20, 1935.)

(Continued on Page 22)



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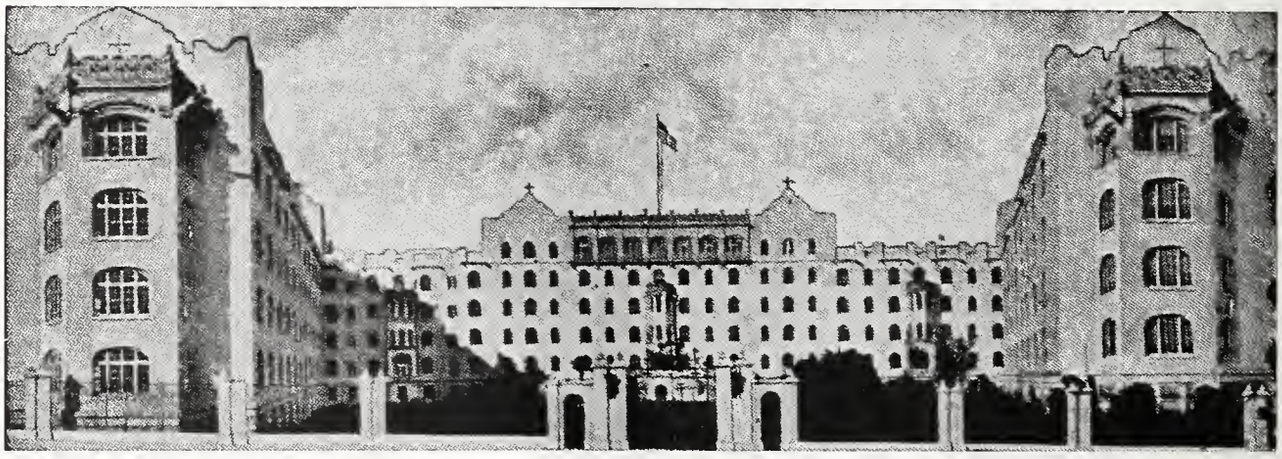
● In short, all of the details in a Yosemite recuperation, or in a vacation, must measure up to standards established for the national parks by the United States Public Health Service. We are always glad, in addition, to cooperate in caring for individual patients. For information regarding any feature of Yosemite living, please write to Don Tresidder, M. D., President, Yosemite Park and Curry Company, Yosemite National Park, California.

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(Continued from Page 20)

"Dr. Frank T. Cary, well-known local physician, who has practiced twenty years in Englewood and Los Angeles, was sentenced yesterday in the Federal Court to a year of imprisonment as a result of a verdict of guilty on five counts of violation of the narcotic law. The sentence of twelve months was given on each of three counts, the terms to run concurrently. Five years of probation was given on the first and fifth charges, and during that period Doctor Cary must not issue a prescription for narcotics. The physician's attorney announced that an appeal would be filed. It is possible that the year's term may be served in a Federal road camp." (Englewood *Californian,* January 10, 1935.)

"Granted two years' probation because of his previous record and his high standing in the medical profession, Dr. Edward H. Williams, noted Brentwood Heights physician, convicted last November of violation of the Harrison Narcotic Law, today was preparing to appeal his case. He appeared for sentence yesterday before United States District Judge Hollzer in Los Angeles. 'I never will be satisfied with probation,' Doctor Williams said. 'I want complete vindication.' Found guilty along with Dr. F. T. Cary, who was sentenced to twelve months' incarceration, Doctor Williams' principal defense in the trial was his interpretation of provisions of the Harrison law relating to the question of pathology." (Santa Monica *Outlook,* January 10, 1935.)

"Fifty-two per cent of California physicians are earning less than $2,000 annually, Dr. F. C. Warnshuis, Secretary of the California Medical Association, announced to members of the Alameda County Medical Association in Hunter Hall, Oakland, last night.

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This figure, he said, is derived from a recent statewide survey which included practically all practicing physicians. . . ." (Oakland *Tribune*, January 23, 1935.)

"G. W. Roberts, former superintendent of the Physicians and Surgeons' Hospital of Glendale, was arrested today in Newark, Ohio, on a local warrant charging him with grand theft, according to advices reaching Inspector William J. Bright at the sheriff's office. According to Bright, Roberts is charged with having obtained $5,000 from a Pasadena woman on a fraudulent stock deal." (Los Angeles *Evening Post-Record*, January 17, 1935.)

"Dr. Ramon Lopez, Brawley physician, was taken last night to Spadra State Narcotic Hospital for treatment, after release ordered by Dorsey Whitelaw, United States Commissioner, and appearance in Superior Court for commitment to the State institution. Doctor Lopez was at the county jail on charges of violating the Harrison Narcotic Act." (Calexico *Chronicle*, January 29, 1935.)

"After being sought by Tehama and Butte County authorities for about ten days on a charge of conspiracy to violate the State Medical Practice Act, Allen Mills of Paradise late yesterday afternoon appeared at the office of District Attorney Clair Engle here and surrendered. Dr. C. E. Brown of Paradise, jointly charged with Mills in a case involving the death of Charles Freeland of Corning, was taken into custody January 26, but Mills could not be found. . . . Mills posted $7,500 in bonds and was released. . . . Relatives of Freeland allege that his death was due to the injection of a cancer cure. Brown is

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

alleged to have injected the serum which is said to have been obtained from Detroit by Mills, following negotiations with the Freeland family." (Sacramento *Bee*, February 5, 1935.) (Previous entries, June and December, 1925; February, 1926.)

"Thomas D. Wyatt, for twenty-one days the physician and health officer for Shasta County, yesterday afternoon tendered his resignation to the Board of Supervisors because he was denied control of the hiring and firing of members of the nursing staff at the Shasta County Hospital. . . ." (Sacramento *Bee*, February 5, 1935.)

"Carl G. Brevis, self-styled divine healer, physician and Government agent, pleaded guilty to vagrancy charges yesterday in Oakland Police Court and was given the maximum sentence of 180 days by Judge Tyrrell. Brevis was arrested February 3, after he had attempted to defraud a group of Oakland merchants. Posing as a federal narcotic agent, Brevis showed a telegram indicating he had $17,000 on deposit in a Federal Reserve Bank. Police learned he had a long record of jail and penitentiary sentences. . . ." (San Francisco *Chronicle*, February 12, 1935.)

"Dr. Rutherford B. Irones, former mayor, who was convicted of hit-run driving, today was ordered committed to the county jail next Friday to serve a six

(Continued on Page 26)

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A study of 8,000 cases of syphilis by five of the outstanding syphilis clinics of the country, in cooperation with the U. S. Public Health Service, revealed that 44% of the cases of early syphilis presenting irreversible blood Wassermann reactions for six months or more, had positive spinal fluids.

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(Continued from Page 24)

months' sentence. He was granted three years' probation, dating from the time he enters jail. Judge G. K. Scovel suspended six months of the one-year sentence on condition that Irones pay all hospital and docor bills incurred by Mrs. George Pickett, wife of a sailor, who was seriously injured in an automobile accident last November 23. While he is on probation Irones is to abstain from the use of intoxicating liquor and is not to leave Southern California without the court's permission. (San Diego dispatch to the San Francisco *Examiner,* February 10, 1935.)

"Major Charles A. Shepard today won his six-year fight against the charge that he murdered his wife, Zenana, to clear the way for his romance with his stenographer, when a jury in Federal District Court today acquitted him after sixteen hours and fifteen minutes of deliberation. It was his second trial. . . ." (Press dispatch dated Topeka, Kansas, February 11, and printed in the San Francisco *Examiner,* February 12, 1935.) (Previous entry, February, 1933.)

Cigarette Smoke. — Michael S. Mulinos and Raymond L. Osborne: Pharmacology of Inflammation, III. Influence of Hygroscopic Agents on Irritation from Cigarette Smoke, Proc. Soc. Exp. Biol. and Med., 32:241-245, 1934. A successful attempt to measure objectively the irritant properties in cigarette smoke is reported. The method used was that described by Hirschhorn and Mulinos: Proc. Soc. Exp. Biol. and Med., 28:168, 1930. A study of the influence of hygroscopic agents on the edema produced on the conjunctiva of rabbits is given. The hygroscopic agents most commonly used in cigarettes are glycerin and diethy-

(Continued on Page 28)

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—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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(Continued from Page 26)

lene glycol. It was stated that "It is obvious that the cigarettes which have been made with diethylene glycol as hygroscopic agent prove to be less irritating than those with glycerine." Not only was the irritation greater in the case of glycerin than from diethylene glycol, but it lasted a longer time. It is further stated that "the edema produced by the smoke solution from the untreated cigarette lasted an average of thirty-one minutes (8-82); that from the diethylene glycol lasted eight minutes (0-21); and that with the glycerin lasted forty-five minutes (17-122.)"

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Medical Society of the State of New York—Health Insurance. — Stigmatizing the health insurance bill pending before the state legislature as a measure under which patients would get poor medical care, and physicians would degenerate into callous machines, Dr. Jacob L. Moreno of New York City appeared to enter his protest against the law. He told members of the Legislative Committee, Medical Society of the State of New York, his experience during six years under health insurance in Austria.

"All such schemes," he said, "operate to make physicians into mass-production machines turning out standardized treatment to patients. Every patient is an individual medical problem. Health insurance cheats



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both the patient and the doctor. In the name of trying to advance human welfare, such measures actually retard progress."

Doctor Moreno is director of research, New York State Training School for Girls, Hudson, New York, and adviser of the Subsistence Homestead Division, Department of the Interior, Washington, D. C.

"I know from experience with the actual reality," said Doctor Moreno, "that no matter how rosy the picture of ideal care for the poor that is presented by such schemes for health insurance, in practice they do not work. They cannot work, because they fail to take account of factors in human relations which are indispensable to the practice of the healing art.

"No physician," added Doctor Moreno, "is capable of properly treating the large number of patients sent him under health insurance. So he is forced to evolve some mass-production plan of operating his office to run people through his mill as fast as possible. A quick look, a stock prescription, a pat on the back, and out the door.

"The 'rush' system of handling patients is inevitable. When the technique of getting them in and out fast enough is perfected, the doctor begins to lose that intangible 'something' which is vital to both himself and his patient—his morale. I do not know any doctor who remained long at this sort of practice in Austria who did not become hardened. A doctor's personal interest in his patient is essential. The response he makes emotionally to the trust reposed in him is important. If the patient comes to the doctor because of confidence in him and not merely because he is an insurance doctor, interest and insight are quickened. Mutual free choice is basic to good medical care.

"Every person's capacity to expand emotionally, and to sustain a confidential relationship, is limited. A physician may be able to maintain a keen mental activity while examining a few cases a day, but after his limit is reached the power to sustain the faculties on a high plane wanes, until, finally, when the last case of a long line is reached, the patient becomes merely a serial number on a piece of paper. Health insurance forces on the doctor an utterly impossible human task—to sustain a genuine personal interest in all the individuals of a miscellaneous crowd at his door.

"The insurance doctor does the best he can, but patients suspect they would get better attention if they came to him during his private office hours, when he could give them more time. This is a distinct and definite injury to the character of the physician. He must hurry through his insurance patients so that he can have plenty of his best self left to take care of his private patients. This is a corrupting influence. He knows he has not lived up to the highest tenets of his profession to give his best to every patient who comes to him. He has been forced by circumstances enacted

(Continued on Page 31)

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by a law to do less than his best by some of his patients, and even his best with the few who see him privately gradually becomes not so good as it was once.

"Nobody who has not seen such schemes in practice as I have, can realize how odious they are. They destroy everything that makes the healing art effective. A new face comes between the doctor and the patient, that of an inspector or supervising physician, or an insurance bureau bookkeeper, questioning this and that particular, without the intimate understanding derived from having seen and known the patient. At best, the real patient, the one for whom the mass production doctor is working, whom he must please if he is to live, is not the sick man, but an adding machine in the office of a bureaucrat who pays the fees out of an insurance fund. This man does not care whether the patient lives or dies, only how much he costs the fund. And his influence is exerted only in the direction of economy and other externals.

"Supervisors are needed in health insurance organizations. A good controller or supervisor who brings in many complaints against doctors is a good supervisor—he is headed for promotion because medical practice has now become a business instead of a profession. Thus, do we destroy a truly healing relationship of which trust and confidence is the basis, and substitute a chain-store, cut-rate imitation, which corrodes curative values needed to heal the sick.

"The system which we now have in the United States is not perfect. But I know from personal experience that the conditions imposed by health insurance are far worse. Health insurance is a type of socialized medicine. It is impossible to socialize the doctor unless the business man, the banker, and the lawyer are socialized, too. Until the time comes, if it ever does come, when we have communism or some form of collectivism, health insurance simply will not work. Though it applies only to the lower income groups, those groups will always feel they are getting less than they ought to get, even if the doctors are men of quality having lucrative private practices in addition to their insurance practice. Like all halfway measures, it will fail, despite the well-meaning altruism of those who sponsor such legislation. They do not realize, as the physician does, who has practiced under such a system, how destructive it is to quality in medical care.

"Letters which have come to me recently from former patients in Austria state that conditions are no better now than when I left five years ago, but are worse, if anything."

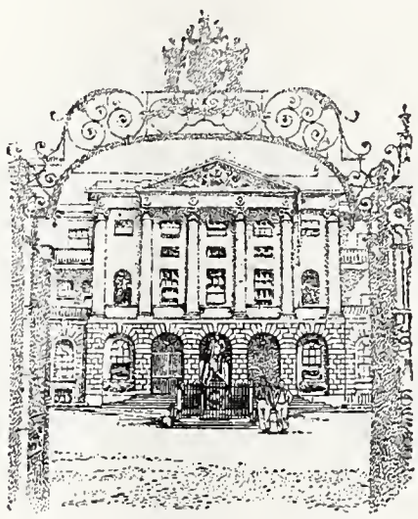
Less Lead Permitted on Apples and Pears.—In a notice addressed to both consumers and producers of apples and pears, Secretary of Agriculture Wallace recently announced a further restriction in the quantity of lead residue permitted on these fruits in interstate commerce. The tolerance specified for the crops of 1935 is 0.018 grain of lead to a pound of fruit. The reduction was made despite requests from some quarters that the restrictions be relaxed, the Secretary adding that "expectation of continued progress downward is fully justified" and "relaxation in the lead restriction would be wholly incompatible with public safety."

The Food and Drug Administration will proceed against violators of the restrictions. Other spray residues for which tolerances are enforced are those containing arsenic or fluorin. The fruit industry, Secretary Wallace says, has demonstrated its ability to reduce the arsenic content to the world tolerance of 0.01 grain of arsenic trioxid to a pound of fruit. The official notice continues this tolerance for 1935. The fluorin tolerance also remains at this same point (0.01 grain to a pound of fruit). The reduction on lead is from 0.019 to 0.018.—*United States Department of Agriculture.*

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THE TREATMENT OF CHRONIC ARTHRITIS BY DIET AND SUNLIGHT*

By Lovell Langstroth, M. D.
San Francisco

Discussion *by LeRoy H. Briggs, M. D., San Francisco; R. Manning Clarke, M. D., Los Angeles; W. D. Sansum, M. D., Santa Barbara.*

THIS paper is based on a review of 100 cases of chronic arthritis seen in private practice. My aim in reading it is, first, to present the results of a study of these cases; second, to give the newer dietary methods that are used in the treatment of chronic arthritis; and third, to draw certain conclusions in regard to the nature and origin of chronic arthritis.

Because of the very brief time at my disposal, I intend to depart somewhat from the usual manner of presenting a medical paper, and omit practically all detailed discussion of the literature. It will be sufficient to state that the dietotherapy of arthritis is based on the work of Pemberton [1] and Fletcher.[2] It *is* necessary, however, to go briefly into the question of diagnosis, because each of the two main types of chronic arthritis, the degenerative, and the proliferative, of Nichols and Richardson,[3] require different methods of treatment. Each of these types also presents a distinctive pathologic picture.

TYPES OF CHRONIC ARTHRITIS

In the *degenerative type,* there is a primary degeneration and then an erosion of the joint cartilage, with hypertrophy of cartilage and bone at the periphery of the joint, but no adhesions or ankylosis. This type is evidently not infectious. In the *proliferative type,* there is proliferation of the endothelial structures in the joint, pannus development over the articulating surface of the cartilage, and destruction of cartilage by granulation tissue from both the joint side and the epiphyseal side. Adhesions and ankylosis do occur.

The proliferative type seems to have the nature of an infectious disease, though there is a great deal of doubt as to whether the attenuated streptococcus, said by Cecil [4] to be found in the blood stream and joint tissues, is really the primary cause of the disease.

Degenerative arthritis is much more frequent than proliferative arthritis. In the 100 cases which were studied as a basis for this paper, there were seventy-seven cases of degenerative arthritis and only eight cases of proliferative arthritis, a ratio of nine to one. The average age of onset in these seventy-seven cases was forty-four, which makes this disease one of middle life. When grouped according to constitutional type, i. e., as to whether they were broad, average or slight, the average was found not to differ from that of a group of 100 controls. This form of the disease was found to involve the spine in fifty cases, the knees in twenty cases, the fingers in nineteen cases, and the shoulders in seventeen cases. While males and females were about equally affected in the spine, females had more frequent involvement of the knees and fingers, and males of the shoulders. But as the duration of the disease in years increased, there was a tendency for more than one joint to be involved, and finally for all the joints to be involved. The symptoms generally appear insidiously with stiffness and "cracking" in the joint after inactivity, as in the knees after sitting; but pain on movement soon follows, and then increasing disability. In the fingers, hypertrophy of bone at the periphery of the joint is quite evident on inspection, and similar hypertrophy is shown by roentgen rays in other joints, although, in my opinion, roentgen-ray evidence is not necessary to establish a diagnosis.

In proliferative arthritis, the average age of onset was thirty-two, and this was also the age of onset of a group of miscellaneous diseases in the group of controls, so this form of arthritis appears at a much younger age. And while in degenerative arthritis the patient will often say that, apart from his affected joints, he is perfectly well, this is rarely the case in proliferative arthritis, where he will often complain of fatigue, loss of strength, and a general sense of not being well. The soft parts about an affected joint seem thickened, the capsule usually contains fluid, the joint has a typical fusiform shape, motion is limited and painful, there is marked tenderness on pressure, and muscular atrophy may be marked. The affected joint may clear up for a time, only to reappear in a year or more; and if the disease is not arrested there is a marked tendency for all the joints to be involved, and finally for the patient to become utterly helpless in bed.

* Read before the General Medicine Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

BORDER LINE TYPES

While it is easy to differentiate these two types of arthritis, there are many cases which it is difficult to classify properly. These cases seem to be intermediate between the extremes of degenerative arthritis on the one hand, and proliferative arthritis on the other. It thus seems possible for the degenerative type to be complicated by what may be called the infectious element, as it was in eight of my cases; or for milder degrees of "infectious arthritis" to remain localized to one joint, or to clear up without going on to the typical picture of proliferative arthritis, as in four of my cases. This form of infectious arthritis is often limited to one or two joints, though it may wander from one to another and involve so many that it is difficult to distinguish it from atypical forms of rheumatic fever. The more acute forms tend to recover spontaneously with rest and simple measures. The subacute forms not infrequently clear up when diseased tonsils or abscessed teeth are removed, and are probably responsible for the hypothesis that infectious arthritis is always due to focal infection.

RESPONSE TO DIETOTHERAPY

Degenerative arthritis is usually favorably affected, or completely relieved, by proper dietotherapy, though some cases seem to resist treatment. Thus in seventy-two cases treated by diet, five were not improved, thirteen were slightly improved, thirty-nine were much improved, and fifteen were completely relieved. Curiously enough, the chances of relieving the patient seem to vary directly with the inadequacy of his previous diet. It has been my custom for some years to take and record a dietary history on each patient, and while these histories show that the average diet of the seventy-seven patients with degenerative arthritis does not differ from the average diet of the 100 control cases in respect of the percentage of protective foods, they do show that when a diet high in protective foods is instituted, relief will be most striking in those cases where the inadequacy has been greatest, and particularly when the amount of bread eaten has been greatest. If we divide my seventy-two treated cases into two groups on the basis of their improvement, following a diet of protective foods, we find eighteen cases not improved or slightly improved, and fifty-four cases much improved or completely relieved. If we then compare the dietary histories of the first group with those of the second, we find that the diet of the second group (that made the greatest improvement), contained 30 per cent more bread than that of the former group (which made the least improvement). Perhaps it is not fair to single out bread in this way as having an unfavorable effect on degenerative arthritis, but it is the food which is generally substituted for the protective foods, and its presence in unusual amounts is thus an indication of a gross deficiency in respect of these protective foods. At any rate, it was the food which stood out most prominently in these dietary histories as having a relation to improvement when a proper diet was instituted.

TABLE 1.—*Depletion Diet*

Breakfast
Glass of orange juice
Fresh raw fruit
Black coffee
Luncheon
Glass of orange juice
One-third head of lettuce with French dressing and tomatoes or any raw fruit or vegetable
Two fresh cooked vegetables
Fresh raw fruit
Dinner
Same as luncheon

DEPLETION DIET

The average patient with degenerative arthritis is ambulatory, but occasionally a severe attack of pain in sacro-iliac arthritis, or fluid in the knee joint, will necessitate his being put to bed for a time. His general health is usually fairly good, and it is not necessary to insist on as much rest as in proliferative arthritis. The diet given depends on his weight, age, activity, and appetite. Middle-aged, inactive and overweight patients are given what I call a depletion diet, provided I can be sure of seeing them several times a week for the first few weeks of treatment. This diet is given in Table 1.

This depletion diet is bulky and very high in protective foods, but contains very little protein and fat, and no concentrated food except the salad dressing. I instruct the patient not to continue it longer than three days without consulting me. Not infrequently he returns after this interval with some evidence of improvement, but he may complain of weakness, dizziness, and sweating, which, in my experience, are associated with the change in the character of his food, and not with the lowered caloric intake. I like to wait until he insists that he is very hungry, and then I increase his diet by adding small amounts of food at two or three-day intervals until I have added two or three glasses of milk, two eggs and a serving of meat, fish or chicken, the object being to prolong the period of depletion and to slowly institute the full basic diet of protective foods. During this period of depletion there is often a loss of eight or ten pounds weight, and usually a marked improvement, with gradually increasing freedom from pain, stiffness and disability. The patient feels better generally, and looks better, too, particularly as to quality and color of skin, and brightness of sclerae.

DIET OF PROTECTIVE FOODS

When the patient has only a small amount of pain and disability, or is forced to continue actively in his occupation, the basic diet of protective foods is prescribed at once. This diet is given in Table 2.

It is usually possible to maintain a satisfactory weight and to satisfy the appetite on this diet, as the patients are in middle life, and not doing physical labor. If it proves inadequate, Ry-krisps, potato, or whole wheat bread can be added in small amounts, though I prefer to make additions of milk or fruit, if nourishment can be maintained on them.

TABLE 2.—*Basic Diet of Protective Foods*

Breakfast

Glass of orange juice
Two eggs
Fresh fruit, preferably raw, but cooked occasionally, with a minimum of sugar and no cream
Glass of milk, heated and taken with coffee if desired but without added cream or sugar

Luncheon

One-third head of lettuce with French dressing and added tomato or any raw fruit or vegetable
Two fresh cooked vegetables
Glass or two of milk
Fresh fruit
Glass of orange juice

Dinner

Meat, fish or chicken
One-third head of lettuce with additions as above
Two fresh cooked vegetables
Glass of orange juice
Fresh fruit
Cheese, fresh nuts, raisins, dried figs, or dates

No soup, cereal, starch, paste, sugar, cream or butter (except in cooking). No bread, potato, or canned food.

PHYSIOTHERAPY AIDS

Physical therapy is a helpful adjunct to dietotherapy at times. Actinotherapy has a good general tonic effect on the tissues; heat and diathermy are useful in spinal arthritis with referred pain down the arm (the so-called neuritis), and massage of the back muscles is helpful occasionally in spinal arthritis. Postural exercises are particularly important in sacro-iliac disease and arthritis of the spine, but should generally be used after the pain has been controlled by diet.

TREATMENT IN PROLIFERATIVE ARTHRITIS

The approach to proliferative arthritis is quite different. When the disease is well advanced, the patient is often underweight and fatigued, and looks ill. He will not make progress under any régimen unless he can be put at rest, but this does not mean that he must be in bed. Since his treatment must be continued for several years, the wisest practical course is to allow him what small amount of activity he is able to take, and let him be up and around his room, house, and yard. Immobilization of the joints seems indicated on theoretical grounds, but is often impossible because so many joints are involved. The full basic diet of protective foods, or as much of it as can be taken, is given at once. Heliotherapy is almost indispensable in proliferative arthritis, and artificial sunlight is a poor substitute. The patients who have done best are those who have moved into regions where sunbathing is possible for eight months of the year. After the patient is thus established, and treatment begun, there is an interval of several months before improvement begins; and during this period every effort must be made to support his morale. When improvement does begin, it first becomes evident in a general way: the patient feels and looks less fatigued, has a better color, and better digestive function. This is followed by a decrease of swelling and pain in some of his joints, and from this point on progress is slow but fairly steady, though there may be discouraging periods of fever and relapse. When all signs of activity have disappeared in the joints, then massage, passive, and active movements are begun, and continued so long as there is hope of increasing the range of motion. Motion in some of the joints may be impaired or lost because of ankylosis and subluxation; but, in spite of these permanent disabilities, the patient is no longer a hopeless invalid, and is often able to lead a life of moderate activity.

TREATMENT OF INTERMEDIATE TYPES

The type of arthritis which I have classified as intermediate between degenerative and proliferative is often restricted to one or two joints such as the shoulder or knees, and these joints then contain fluid and are sometimes quite painful. If the case is seen from the beginning, it is best to immobilize these joints in some form of splint for a few days till the pain is relieved, and then gradually remove the support for institution of massage, passive motion, and diathermy. When this sort of immobilization is added to the dietotherapy and actinotherapy, such a joint will often be restored to full function in a few weeks.

While improvement has been marked in both types of arthritis under the treatment outlined, it is a striking fact that any considerable relaxation of vigilance as to diet in the degenerative group, or rest and sunlight in the proliferative group, will soon bring on symptoms. In other words, we have succeeded in arresting the progress of the disease, or in restoring painless function, but we cannot be said to have cured it in any sense, for the old environmental conditions will allow it to progress again.

RÔLE OF FOCAL INFECTION

Focal infection has commonly been held responsible for all types of arthritis, the theory being that abscessed teeth or diseased tonsils served as a portal of entry for the streptococcus, which secondarily infected the joints. I found a history of such focal infection to be more frequent in my seventy-seven cases of degenerative arthritis, and much more frequent in my twenty-one cases of infectious arthritis, than in the control group. I believe these figures indicate that patients with proliferative arthritis, at least, are more susceptible to focal infection. When this susceptibility is considered in relation to the occasional miraculous cure of an arthritis of the intermediate type by extraction of an abscessed tooth, and to the fact that the activity in proliferative arthritis is slowly overcome by measures calculated to raise the patient's resistance, it strongly supports the notion that the disease is infectious, and that the attenuated streptococcus is its cause. On the other hand, the removal of foci was not beneficial in my eight active cases, for six had had their tonsils cleanly removed, and all had had their abscessed teeth removed, and there seems to be a clear relation between recovery and protective foods and sunshine, so that it is quite possible that we are dealing with a deficiency tissue disease related to vitamin D, and that the attenuated streptococcus is merely a secondary invader. But even if this streptococcus is eventually found to cause the lesions, I believe that it is only able to gain a foothold in these persons because of a primary lack of resistance. This attitude toward focal infection seems to me extremely important because of its

therapeutic implications. If the patient's lowered resistance is primary, and the invasion by the streptococcus secondary, then our main therapeutic efforts should be directed toward raising his resistance, and removal of diseased tonsils and dead teeth should play a secondary rôle.

INFLUENCE OF ENVIRONMENTAL FACTORS

Thus far, the evidence presented tends to show that both forms of chronic arthritis are influenced favorably by environmental factors, and that food constitutes the important environmental element in degenerative arthritis, and rest and sunlight in proliferative arthritis. I should be happy to say that the histories of these patients showed that their diet or their sun exposure had been below the average, but this is not the case. The patient with degenerative arthritis takes about the average diet in regard to protective foods, and the patient with proliferative arthritis has not had less sun exposure than the 100 controls. In other words, we face the paradox that environmental factors can be shown to overcome both forms of chronic arthritis, but cannot be shown to have anything to do with their origin. Our dilemma is made worse by the fact that the disease is held in abeyance only so long as the improved environmental conditions are maintained. I have tried to answer this riddle by assuming that these patients developed chronic arthritis because of a tendency inherent at birth—a tendency to degeneration on the one hand, and to infection by whatever attenuated organism may eventually be proved responsible on the other. Degenerative arthritis would thus be explained by the occurrence in certain persons of an inherent tendency to degeneration of joint cartilage under ordinary dietary environment, but this tendency would be held in abeyance by special dietary environment. Proliferative arthritis would be explained by the occurrence in other persons of an inherent susceptibility to infection of the joints with some attenuated organism; but this susceptibility, too, would be held in abeyance by special environment as regards foods, rest and sunlight.

IN CONCLUSION

Degenerative arthritis is probably due to an inherent tendency of the joint cartilage to degeneration, and this degenerative process is modified by the food intake. A diet high in protective foods usually gives relief from symptoms.

Proliferative arthritis is probably due to an inherent tendency to infection of the joints by some attenuated organism. This infection may be overcome by prolonged sun treatment and a diet high in protective foods.

516 Sutter Street.

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DISCUSSION

LeRoy H. Briggs, M. D. (384 Post Street, San Francisco).—The question of the efficacy of any treatment in such a chronic disease as arthritis is surrounded by so many variables that conclusions, other than that by the infallible test of time, are well nigh impossible. Two of the most characteristic features of the degenerative type are the fluctuations of the symptoms and the permanence of the bony changes, the former being based largely on subjective evidence, the latter on objective. True, in the soft-tissue variations of an acute exacerbation and decrement, we have objective evidence of change; but these may occur spontaneously and apart from any treatment. One starts, therefore, with the premise that evidence of improvement dependent on a given therapy is mainly subjective, and more or less of an uncertain quantity. Furthermore, the hope engendered in the mind of the patient by a new and definite mode of treatment, enthusiastically supervised, is certain to achieve psychic improvement, even though temporary.

There is no question that the reduction in surplus weight of the soft obese arthritic patient is a betterment, relieving the joints, especially the larger weight-bearing ones, of two of the most pernicious factors of the disease, strain and fatigue. This is of definite benefit, provided it is not carried too far; but one feels that it is immaterial as to how this caloric lowering is done, for it would seem that the improvement results from the actual loss of weight rather than from the removal of any suppositively deleterious elements in the diet. It is as yet far from proven that intestinal fermentation and putrefaction are etiologic elements; and as for a high vitamin diet, the adult on an ordinary ration certainly gets an adequate quota for his needs.

In the proliferative type, a low diet may possibly be a detriment rather than a benefit. These people usually are undernourished and depleted, partly from the nature of the disease as well as all too often from various dietary procedures previously attempted in the hope of cure. Personal experience appears to point that feeding them to bring about a better state of nutrition is more productive of good than harm, as in the case of any chronic infectious process.

As far as actinotherapy in arthritis is concerned, no clinical proof yet has been offered that any benefits result other than those derived from a changing circulation. In a degenerative process, and to some extent in a chronic low-grade infectious one, an increased vascularity of even the tissues peripheral to a joint might be of use. The immense present popular appeal of the method, together with the visual evidence of a change in color, might in many instances bolster up the general morale of a patient, depressed by the contemplation of a chronic process undergoing a therapeutic standstill.

It must be admitted that a certain tinge of pessimism has been induced in the mind of one who has seen these patients over a period of years, not with the eye of the specialist temporarily scrutinizing damaged joints, or surveying varying foci of infection, but from the broader horizon of the practitioner of medicine, noting what mediocre success greets the numberless therapeutic trials over the span of time. However, any measure that inspires hope and builds up morale, even for a short time, is well worthy of use, provided it does no harm. Faith sometimes may accomplish the seemingly miraculous.

❦

R. Manning Clarke, M. D. (1219 Hollingsworth Building, Los Angeles).—This paper is certainly timely, since, like the poor, we have these arthritics always with us. I am grateful to the Doctor for bringing once more forcibly to our minds the things that can be done to help these sufferers. The work of Pemberton most of all, but also of Richardson, Cecil, Fletcher and others have been well received. Doctor Langstroth has set us an excellent example in his ability to use this knowledge for the relief of his patients; and what is more important, how to use

it as a vehicle of study, and a road to more knowledge. We all look forward to the day when the etiology of arthritis will be more definitely understood. In the light of that day we will, of course, have better and more intelligent treatment.

One of the interesting things brought to view in these studies of arthritis was that the sugar tolerance showed a tendency to be lowered. Fletcher found that "a large majority of his cases studied showed a lowered sugar tolerance." He found that women showed a greater improvement and response to diet reduction than did men, and also that they usually showed a lower sugar tolerance. Doctor Langstroth has no doubt noted this improvement in sugar tolerance, while his cases were on the depletion diet he has shown us, especially if they were female and obese.

I desire to especially note in passing that I like the attitude presented in the paper as regards the subject of focal infection. I think it expresses well balanced, good judgment.

❊

W. D. Sansum, M. D. (Santa Barbara Cottage Hospital, Santa Barbara).—The noninfectious, degenerative type of arthritis is a disease of unknown cause for which the treatment has been unsatisfactory. Doctor Langstroth's work seems to show that diets high in protective foods, together with sunshine, are valuable adjuncts in the treatment of this condition, and also in the treatment of the infectious, proliferative types. Inadequate diets might be one of the causes of the degenerative type, and they might lower one's resistance to infection.

Allergic arthritis is probably more common than we formerly supposed. It may be that the depletion diets used in the beginning help an allergic factor, if present.

❊

Doctor Langstroth (Closing).—In the investigation of any clinical problem there are two forces at work—a positive constructive or creative force, which aims to modify a disease process, or to better the actual conditions, and a negative, destructive or denying force, which aims to maintain the *status quo*. One tends to interpret the phenomenon in the light of its own creative will, and may therefore distort the facts and see only what it desires to see; the other tends to interpret the phenomenon in the light of its negative will, and may therefore fail to see what it desires not to see. The latter force is only healthy in so far as it keeps the former from going off into unreality. In this investigation I have tried to maintain a proper balance between these two forces. I do not claim to have found methods of treatment that are universally or completely successful, but to have merely pointed out certain conditions which modify the disease process in arthritis. The work itself is an attempt to apply the newer knowledge of nutrition to a phase of clinical medicine where therapy heretofore has been quite sterile. The diets used are based entirely on the work of such men as McCollom and McCarrison, and therefore have a good scientific background. Those of my associates who have seen this work in the clinic are convinced that the results are not overstated.

Much of the criticism directed against the advances in our knowledge and application of the principles of good nutrition is more revealing of a general attitude than convincing as argument. A large part of such criticism comes from individuals who are uninterested in nutrition, and have never made a careful trial of the methods they criticize. It cannot be refuted in detail because it merely denies; it is an attempt to rationalize the negative will to maintain the *status quo*. It is as much as to say: I do not think these results can be possible; therefore the results are not factual.

It is interesting to consider for a moment the psychological motivation of this negativistic attitude. Maintenance of the admittedly unsatisfactory *status quo* is evidence of fear of change, and this fear of change in turn is evidence of a narcissistic fear of making a mistake. In other words: rather than run the risk of making a mistake I will remain static; that is much safer.

LYMPHOGRANULOMA INGUINALE*

REPORT OF A CASE ORIGINATING IN NORTHERN CALIFORNIA

By Frederick G. Novy, Jr., M. D.
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Discussion *by Eugene F. Hoffman, M. D., Los Angeles; Samuel Ayres, Jr., M.D., Los Angeles; Anthony B. Diepenbrock, M.D., San Francisco.*

Lymphogranuloma inguinale (Lymphophathia venerea) was first described as a separate clinical entity in 1913 by Durand, Nicolas, and Favre [1] of France. This condition had previously been observed and reported under various names, as climatic bubo, strumous bubo, tropical bubo, non-venereal bubo, and non-tuberculous lymphadenitis. Apparently the first report was in 1859 by Chassaignac,[2] who cited cases of peculiar inguinal lymphatic masses. From that time on, various reports were made of this condition, coming mostly from tropical countries.

After the first report by Durand, Nicolas, and Favre, little interest was taken in the condition until after the World War. In 1922 they again brought the disease to the attention of the profession in a long and exhaustive study.[3]

Many articles have been written on the subject since this time, and several other names for the malady have been suggested, such as the "fourth venereal disease." This, however, immediately conflicts with some of the English writers, who feel that granuloma inguinale should be the fourth disease, Vincent's infection of the genitals, the fifth disease, and that lymphogranuloma inguinale should be called the sixth. Wolf and Sulzberger [4] suggested the term "lymphophathia venerea," which is by far the best, in that it is not confusing with granuloma inguinale and implies its venereal nature and involvement of the lymphatic structures. However, the term is open to some criticism in the use of the word "venerea."

The rapid spread of the recognition of this condition was augmented by the discovery, in 1925, of a specific test for the disease by Frei. In the next three or four years after the announcement of this test nearly every country had reported some cases, and its almost universal incidence was recognized. Recently several extensive articles on this disease have appeared in this country, and for a complete review of the literature the reader is referred to such comprehensive articles as those of De Wolf and Van Cleve,[5] Zakon,[6] and Cole.[7]

DISTRIBUTION IN THE UNITED STATES

For many years naval and public health officers have reported in ports of this country cases of climatic or tropical bubo. Most of these patients gave a history of having been in the tropics, and they were thought not to have received their infection endemically. These cases were probably in many instances lymphogranuloma inguinale.

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In 1924, at Boston, Hansmann,[8] under the title of "non-tuberculous granulomatous lymphadenitis," published a series of cases which probably were examples of this condition. In 1927 Barber and Coogle,[9] using the same term, reported cases from Mississippi.

The first case reported using the term "lymphogranuloma inguinale" was that reported by Hillsman, Wilshusen, and Zimmerman[10] in September, 1928, from New Haven, Connecticut. In December, 1929, Gross[11] presented a case at the New York Academy of Medicine, and since then at the different medical meetings in that city many new cases have been shown. For several years it was felt that this disease was confined to coast cities, being brought into this country by sailors from abroad. However, this view rapidly changed when De Wolf and Van Cleve[5] in 1932 reported a remarkable group of fifty-eight cases from Cleveland. Subsequent reports bring the total to nearly one hundred cases seen in that city, many of them endemic and of years' duration. In the same year Amtman and Pilot[12] reported three cases from Chicago, two of which were acquired locally. Tomlinson and Cameron[3] had three cases in Omaha in 1933. One of these apparently contracted his infection in Kansas City.

In the South, so-called "climatic bubo" has been long recognized, and in the past year Brown[14] has noted several cases in dispensary practice in Jacksonville, Florida. They were definitely lymphogranuloma inguinale, and he states[15] that he feels it is more common than chancroidal infection in that locality. De Wolf[16] has recently seen one case in Little Rock and another in Hot Springs, Arkansas.

Here in California, Hoffman[17] reported eleven cases from Los Angeles in November, 1933. Eight of these contracted their infection in Los Angeles County.

It appears from the above that this disease is widespread throughout the country, and is not limited to coastal areas. In all probability, it has been present for a long time, unrecognized as a separate disease, and called either chancroidal or gonorrheal bubo.

Now that so many reports have been made, new cases undoubtedly will be appearing in the other sections of the country.

CLINICAL DESCRIPTION

Lymphogranuloma inguinale starts with a primary lesion which appears a few days post coitus. This lesion is ordinarily transitory and benign in character, so that the patient frequently is not aware of its existence. This is particularly true in women in whom it is usually on or near the cervix or folds of the labia. Four types of primary lesions have been noted: (1) herpetic, (2) ulcerative, (3) nodular, (4) nonspecific urethritis, with scanty thin discharge which is negative for organisms. The first of these is by far the most frequent and remains only a few days, resembling a herpes praeputialis.

After a second incubation period of between ten days to three weeks, the patient begins to notice a swelling in one or both groins. This is often associated with general malaise and fever, which is usually from 39 to 40 degrees centigrade (102.2 to 104 degrees Fahrenheit) and may last for several weeks. Other constitutional symptoms, which may accompany the enlargement of lymph nodes, are gastro-intestinal upsets, pains in the joints and muscles, headaches, toxic manifestations on the skin as erythema multiforme and erythema nodosum.

The glands are usually unilateral, but may be bilateral if the primary lesion is near the mid-line. At first they are hard and tender, but not particularly painful. As they increase in size they fuse to form a large mass. The overlying skin becomes tense, shiny, and later takes on a reddish violet color. Not infrequently the skin becomes attached to the inguinal mass. Areas of softening then occur in the glands, which break down, developing numerous fistulous openings from which drain a thick purulent pus. As new areas become involved this cycle continues with softening and sinus formation. In more severe cases this may spread to involve the deeper lymph glands of the pelvis and about the rectum; here they do not usually break down, but as the infection subsides become fibrotic. Ordinarily, after draining for some months the sinuses close and heal spontaneously, but occasionally they may remain open and drain for years.

In females the clinical picture is quite different in that the primary lesion is on the cervix or posterior fornix, so that the deep pelvic nodes are almost immediately involved, giving rise to vague lower abdominal symptoms. If, however, the site of invasion is about the external genitalia, the superficial inguinal nodes will be involved. The end-result of this involvement is blockage of lymph drainage of the vulva and the resultant elephantiasis of the labia which may break down, forming fistulous tracts and ulcers. This condition has been described as esthiomene and has long been known under this name.

The most serious complication of this disease is the involvement of the pelvic lymph-nodes, resulting in fibrosis of the nodes and finally rectal stricture. This is naturally more common in females because of the lymph drainage.

Years ago Fournier described a syndrome of multiple sinuses draining into the rectum or perineum. Associated with this was an infiltration of the rectal wall with stricture formation. He believed that the syndrome was on a syphilitic basis, and it has been known as the anorectal syphiloma of Fournier. However, this condition has never responded to specific therapy. Since the introduction of the Frei test many of the cases that were previously thought to be syphilitic have been shown to be cases of lymphogranuloma inguinale. Martin[18] recently reported a series of twenty-five cases of stricture of the rectum, of which twenty showed positive Frei tests. Streicker, in the discussion of this paper, had a series of nineteen cases, all with positive Frei tests.

ETIOLOGY

From the nature and course of the disease it has long been thought to be of venereal character,

and many cases have been cited of transmission by sexual intercourse. Extragenital infections are rare. Two cases involving the finger have been observed, one by Hellerström and the other by Ravaut, both of these being in physicians. Curth [19] and Bloom [20] have recently reported a case of primary involvement of the tongue with cervical adenitis. Other extra-genital cases have been observed.

This disease has been shown to be due to a filterable virus by Hellerström and Levaditi, Marie and Lepine.[21] They have inoculated apes subdurally and have been able to carry the virus through a series of animals and then reproduce the disease in humans by means of preputial inoculations. Filtrates from the emulsion of brain and spinal cord of inoculated animals have given a specific intradermal reaction similar to the Frei test. The picture seen in monkeys is that of a fatal meningo-encephalitis. Successful inoculations to rabbits, guinea-pigs, and mice have been reported in some instances.

The virus is resistant to cold, but is easily destroyed by heat and loses its virulence in glycerin. Coutts [22] believes that there are two definite types of this virus; one type of genital and the other of buccal origin. This latter type manifests itself with more general symptoms, and there are also two types of antigen, so that one type will not react in a case in which the other type of virus is responsible for the disease. This concept of two distinct viruses will have to be substantiated by further experimental and clinical observation.

PATHOLOGY

Grossly the glands present a mass bound together by thick perinodal exudation often attached to the skin. On sectioning, multiple small abscesses are seen which contain thick creamy pus.

Histologically, the lymph-nodes present a definite granuloma replacing the normal lymph-node structure in which are found numerous microscopic abscesses often stellate in shape, and filled with lymphocytes and cellular débris. These abscesses are walled off by epitheloid cells which are often in palisade arrangement. Plasma cells and leukocytes are seen and occasionally giant cells of the Langerhans type. This picture is thought by some authors to be specific for the disease.

THE FREI TEST

This test has been found to be specific by most workers. The antigen is prepared by diluting the pus from a bubo of a known case obtained under aseptic conditions, with physiologic saline solution. The dilution is 1 : 5 or 1 : 10, depending on the thickness of the pus. It is then sterilized at 60 degrees centigrade in a water bath for two hours on the first day, and one hour on the next day. The solution is tested for sterility and checked on a known positive case. An intradermal injection of 0.1 cubic centimeter of this solution is made and the reaction is read in forty-eight to seventy-two hours. A positive reaction is one which presents an infiltrated papule at least 0.5 centimeter in diameter. Around this there may be a wide erythematous halo. Occasionally the reaction is so severe as to cause local necrosis. The test probably always remains positive many years after the time of infection.

DIAGNOSIS

In all cases of regional lymph-gland swelling, this condition should be kept in mind, and particularly is this true of the inguinal glands. If there is a history of a fleeting genital lesion the chances of dealing with this condition are more than suggestive. A positive diagnosis can be made by the use of the Frei test.

Granuloma inguinale simulates lymphogranuloma inguinale only in name and location, as it is primarily a disease of the skin presenting itself as a superficial, slowly advancing, undermining ulcer which may spread over the entire lower abdomen, but which never involves the lymph-nodes nor invades the deeper structures. Smears from these cases show the Donovan bodies in mononuclear cells, and the Frei test is negative.

In chancroidal infection the adenitis is more painful and acute, and breaks down with one central necrotic area. At the time of the adenitis there are usually several chancroidal ulcers present on the skin in which the bacillus of Ducrey can be found and the Ito-Reënstierna reaction will be positive. This latter is a reaction similar to the tuberculin test. The antigen is made from Ducrey organisms. Auto-inoculations are positive in cases of chancroidal infection and not in lymphogranuloma inguinale.

The adenitis due to syphilis is very different in that the glands are firm, painless, discreet, and do not break down. Darkfield examination and serologic tests also serve to confirm the diagnosis.

Other conditions to be considered are: Hodgkin's disease, lymphosarcoma, pyogenic infection, tularemia, bubonic plague and metastatic glands from a neoplasm.

TREATMENT

Many types of therapy have been advocated for this condition. Most of the intravenous medications have been used with indifferent results. Tartar emetic has probably been the most satisfactory. X-ray therapy has been of little value, and in some instances has aggravated the condition. Incision and drainage in the less advanced cases have proved to be of value. Total extirpation of the glands has the disadvantage in that occasionally an elephantiasis develops in the dependent part due to loss of lymph drainage. Kalz [23] reports good results from the use of convalescent serum. Recently Wien and Perlstein [24] made a preliminary report in which they state that they have had consistently good results with the intradermal injections of Frei antigen. Their method of procedure has been to give 0.1 cubic centimeter intradermally, at three- to five-day intervals. Improvement has been noted after only a few injections. In one case, Thomas and McCarthy,[25] with the use of Besredka type of bouillon filtrate, observed definite and rapid response.

The treatment of rectal stricture due to this disease has been most unsatisfactory until the

introduction of the intradermal injections of Frei antigen. Since then some of these cases have been definitely improved with this type of therapy.

REPORT OF CASE

F. A., age forty-four years, Mexican, living for the past eighteen years in California, entered the surgical department of the University of California Clinic on October 26, 1933, complaining of a swelling in the right groin.

Past History.—The patient has had a Neisserian infection twice. The last infection was several years ago. He has had no symptoms from this for some time. There was no history of syphilis. He has not had any other serious illness, and the past history is otherwise negative.

Family and Marital History.—Of no importance.

Present Illness.—In May, 1933, the patient went North with the Alaskan fisheries, working there until the latter part of July, returning to San Francisco August 12. He denied having had sexual intercourse during this time. Immediately on his return to San Francisco, he had numerous exposures with several women. A week later he noticed a small penile lesion which he described as a "hair cut." This he treated a few days with mercurochrome, and it cleared up promptly. About ten days later he began to notice a swelling in the right groin which gradually increased in size and continued to do so until it broke down with the discharge of pus. There was some pain associated with this, which has been of a dull, aching character, and also some pain radiating down the leg.

For some time, he has had constitutional symptoms of loss of weight, general malaise, and fever. The latter was more noticeable at night and sometimes associated with sweats. The joints of the legs have been painful at irregular intervals. There has been no nausea or headaches.

Examination on Entrance.—The patient presented a large, hard, non-fluctuant mass in the right inguinal region. The overlying skin showed a bluish discoloration and was tense. There were two sinuses present, about two inches apart, along the line of the inguinal ligament. The penis showed no active lesion, but a small soft scar below the corona in the mid-line was present. The right leg presented no pathology on examination. Impression at this time was right inguinal bubo, origin and etiology unknown.

Subsequent Course.—On October 30, 1933, the right inguinal region was opened under general anesthesia, with a wide incision, and drained. Following this there was an increased swelling in the area which gradually subsided. Pus continued to drain freely particularly upon pressure. This was seropurulent in type for the most part, but sometimes was thick and creamy. The bubo was treated with injections of saline and packed with balsam of Peru. After the incision there was very little pain at any time.

Examinations of pus for organisms were negative and a guinea-pig inoculated at this time later showed no evidence of tuberculosis. Urine examination was negative. The blood showed a leukocytosis of 19,000, and the differential was normal. The serology was positive both to the Wassermann and Kahn reactions, but examination revealed no evidence of active lues. The patient was started on a course of bismuth salicylate. Microscopic examination of a piece of a lymph gland taken out at the time of incision showed entire loss of the normal lymph-node architecture, and rather marked generalized edema. The blood vessels were increased in number and enlarged. Most of these were engorged with red blood cells. The walls appeared somewhat thickened and the endothelial cells had an edematous appearance. The most striking observation was the marked infiltrate of epithelioid cells throughout the section. In places this was so marked that the picture was similar to that of beginning or acute tubercle formation. In places the epithelioid cells made strands, but did not take on true palisade arrangement, as seen so frequently in sections of this

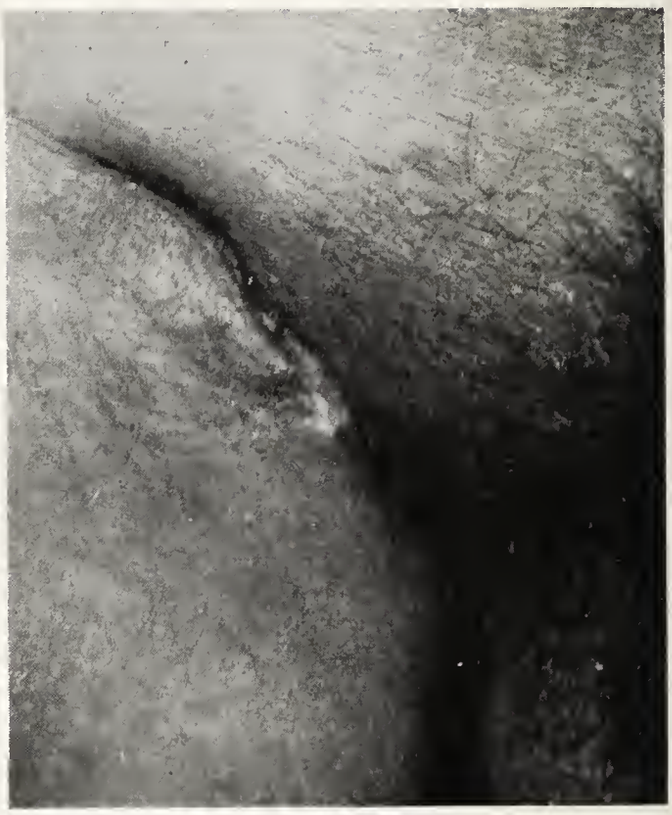


Fig. 1.—Right inguinal region of reported case, showing fistulous opening.

condition and considered by many authors to be most characteristic. Scattered among these cells were many lymphocytes, some polymorphonuclear leukocytes, and a few plasma cells. There were several small abscesses present with a cell type similar to those seen among the epithelioid cells. Cellular and nuclear fragments were present. No giant cells were noted.

As the condition was involuting very slowly, x-ray therapy was instituted which seemed to flare up the condition with an increase in size of the indurated area. Tenderness and considerable more discharge was present, and the process appeared to have extended beneath the inguinal ligament.

On December 4, the patient was seen for the first time in the department of dermatology and presented a large grapefruit-size mass in the right inguinal region. The overlying skin was shiny and tense, and had a deep purplish color. In the center of this was a long opening running parallel to Poupart's ligament. From this considerable purulent tenacious material could be expressed. Associated with this was a generalized adenitis. The spleen could not be felt.

On this date a Frei test was done in the usual manner with an intradermal injection of 0.1 cubic centimeter of the antigen. This antigen was obtained from Doctor Cameron of Omaha. On December 6, forty-eight hours later, the site of injection showed a markedly positive reaction with pustule formation and a wide zone of erythema. On December 11, another Frei test was performed with an antigen sent by Doctor Wein of Chicago. Seventy-two hours later the reaction showed an erythematous firm infiltered papule about 0.5 centimeter in diameter. About this was a wide erythematous slightly infiltered halo. According to the patient it had been more marked the day before.

Slowly the discharge had been getting less and the indurated area gradually became smaller, so that by January 11 only a slight amount of pus could be obtained, and from the 18th on there was no longer any discharge present and the sinus had scarred over. Coincident with this the mass has continued to involute. Another Frei test on January 15 was positive.

It is interesting to note that the patient's condition improved following the Frei tests, and it is suggestive that these may have had some therapeutic effect, as has been shown by Wien and others.

COMMENT

The case reported is clinically typical of lymphogranuloma inguinale, and the diagnosis was confirmed by the use of two different Frei antigens, both of them being strongly positive.

The chief interest of this case, to my mind, lies in the fact that the patient acquired his infection in northern California. Hoffman [17] has reported cases endemic in Southern California.

Other cases have been diagnosed in or about San Francisco in the last few months, but to my knowledge they did not acquire their infection locally. Stewart,[26] at the Marine Hospital, has seen thirteen cases with positive Frei tests, all of these having been in foreign ports recently, except one who received his infection in Los Angeles. Two other patients have come recently under the observation of Brown [27] at St. Francis Hospital. Both of these had just returned from the Orient. Undoubtedly this type of case has, or will prove to be a source of contagion to the inhabitants of ports along the Pacific Coast.

At the December meeting of the San Francisco Dermatological Society, Templeton [28] showed a case of rectal stricture of years' duration in which there was a positive Frei reaction.

In Sacramento, one clinically typical case which was substantiated by the specific test has recently been observed by Schoff.[29] Other cases of this disease are undoubtedly present in the State and its distribution widespread. It is probably going unrecognized as a separate disease and is being considered as chancroidal or gonorrheal bubo.

CONCLUSIONS

This disease is endemic in California, as has been shown by the cases reported by Hoffman and the one herein reported. Many more cases will come to light if a Frei test is done on all cases of inguinal gland enlargement, particularly if sinus formation is present.

From the recently reported high incidence of positive Frei tests in cases of rectal stricture, this test should be a routine procedure, regardless of whether another infection such as syphilis or tuberculosis is present or not. The same holds true for chronic ulcerations and sinuses about the vulva or perineum.

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DISCUSSION

Eugene F. Hoffman, M.D. (1100 Mission Road, Los Angeles).—As Doctor Novy has adequately covered the subject under discussion, I shall report some of our experiences on the urological service of the Los Angeles County Hospital.

In summarizing the records of thirty-five cases since March, 1933, we find:

1. Males, twenty-seven; females, eight.

2. Thirty were under fifty years of age; the youngest being fourteen, whose infection was due to the use of an enema tip also used by her infected mother (accidental infection).

3. Americans (whites), sixteen; Mexicans, ten; negroes, seven; Filipinos, two.

4. Twenty-two were single; nine married; two widowed, and two separated.

5. Source of infection in Los Angeles County, twenty-seven; Texas, four; Mexico, one; Minnesota, one; Philippine Islands, one; unknown one.

6. Longest duration of disease, seven years; shortest, twenty-one days.

7. Primary lesion seen in eleven cases.

8. Eleven were Wassermann-positive; twenty-one were negative; three, one or two plus (became negative under tartar emetic therapy).

9. Twenty-six showed systemic symptoms.

10. Bilateral bubos in nine; right bubos in seven; left bubos in ten; rectal strictures in ten (including two males); both rectal strictures and bubos in two (women); maxillary and supraclavicular glands involved in one; fistulae (rectovaginal, vesicovaginal, abdominal) one each, and meningeal irritation (lymphogranulomatus meningitis), one.

11. Twelve bubos went to sinus formation; fourteen did not.

12. Cures, seventeen; under treatment at present, six; deaths, one (glomerulonephritis); failed to return to clinic for check-up, eleven (healing being evident when last seen).

In my previous report, covering the treatment of eleven cases, tartar emetic was considered almost specific. However, we now feel that our best results have been obtained through the intravenous use of antigen, which is superior in results to its intradermal or subcutaneous use.

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Samuel Ayres, Jr., M. D., (2007 Wilshire Boulevard, Los Angeles).—While cases of lymphogranuloma inguinale are being reported with increasing frequency, it is still far from a common condition. Personally, I have never seen a case in private practice, nor has one ever been presentcd before the Los Angeles Dermatological Society. Practically all of the patients at the Los Angeles County General Hospital have been admitted on the urological or proctological services. Dr. E. F. Hoffman, who has probably seen more cases of this disorder than anyone in Los Angeles, tells me that there have been approximately seventy cases on the urological and proctological services up to the present time (November 25, 1934).

As Doctor Novy has pointed out, the introduction of the Frei test has been of inestimable value, not only from a diagnostic standpoint, but therapeutically as well. In recalcitrant cases it might be worth while to consider maggot therapy. We have rccently had a most gratifying result by the use of maggots in a chronic ulcerative granuloma of undetermined etiology of the thigh of a year's duration. The Frei test was negative in this case, but there were many deep sinuses and undermined margins. In view of the remarkable results by the use of maggots in chronic osteomyelitis, it would seem that they might deserve a trial if the Frei antigen treatment is unsuccessful.

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Anthony B. Diepenbrock, M. D. (450 Sutter Street, San Francisco).—In 1913 Durand, Nicholas, and Favre published an account of this disease and gave it the name "lymphogranuloma inguinale." At that time they were not familiar with a similar entity, now proved to be the same disease, which had been variously described as climatic bubo, strumous bubo, hypertrophic bubo, tropical bubo, non-venereal bubo, and inguinal poradenitis. Bubo, described with the various adjectives named above, had been seen and reported by Trousseau, Jouet, Guerin, Segard, Martin, Ruge, Gooding, Branfoot, Roegholt, and others, in such places as Reunion Island, Mauritius Island, Indo-China, Tonkin, Madagascar, Sumatra, Zanzibar, Madras, Dutch East Indies, and East Central Africa; hence, it was regarded as a purely tropical disease. Trousseau's description, published in 1865, is perhaps one of the best early works on the subject.

European investigations were given an impetus by the work of Durand, Nicholas, and Favre; but these studies were disrupted by the World War.

In 1925, Wilhelm Frei discovered that individuals afflicted with this disease exhibited a cutaneous reaction when inoculated with a heated saline dilution of pus, aspirated from a fluctuant bubo. The application of Frei's phenomenon has led to the identification of various types of this disease, previously described as estriomene, climatic bubo, chronic elephantiasis, ulceration of the vulva, inflammatory stricture of the rectum, and the so-called genito-anorectal syndrome. Further, the application of Frei's phenomenon led to the recognition of the world-wide distribution of the disease.

An excellent review of the literature has been presented us by H. S. Stannus in the "Proceedings of the Royal Society," London, 1932.

American interest was given a great impetus by the work of Cole, De Wolf, Van Cleve, Sulzberger, and others.

I agree with Doctor Novy that the term "lymphopathia venerea," coined by Sulzberger, should be generally adopted in writing or speaking of the malady.

My associates, Doctors Rodney A. Yoell, James J. McGinnis, James W. Morgan, and I presented before the San Francisco County Medical Society in April of this year a report of two cases, locally acquired and perhaps the first to be recognized in this State. These patients, husband and wife, have been under our continuous observation since December 6, 1929, and a case report thereon will be printed in California and Western Medicine.

CHRONAXIA*†

Its Theory and Application to Clinical Neurology—With Presentation of a Portable Chronaximeter

By Henry W. Newman, M. D.
San Francisco

Discussion *by H. Douglas Eaton, M.D., Los Angeles; Samuel D. Ingham, M.D., Los Angeles; Robert Aird, M.D., San Francisco.*

THE power of the electric current to cause muscular contraction, when passed through the animal body, has been a part of medical knowledge for a great many years, but it remained for the pioneers of electrodiagnosis, among them Erb[1] and Duchenne de Boulogne,[2] to apply this phenomenon to the diagnosis of certain maladies affecting the muscles and nerves. All of our present clinical knowledge of the reaction of human nerve and muscle to the faradic and galvanic currents, with the variation brought about by injury or disease, can be traced to the work of these men, performed in the middle of the past century.

Value of Electrical Reactions in Neurologic Practice

There is a tendency in modern neurologic practice to put less and less stress on electrical reactions as an aid to diagnosis. I feel that this is due, not to any lack of a need for the information that might be so derived, but to the fact that, despite the tremendous strides which have been made in the refinement of our other diagnostic instruments in recent years, the determination of

* From the Division of Neuropsychiatry, Stanford University School of Medicine. Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

† From a study supported by a grant from the Rockefeller Fluid Research Fund of Stanford University School of Medicine.

the electrical excitability of nerve and muscle is still frequently undertaken with the same crude apparatus available to our grandfathers. The resultant data, qualitative in nature, and subject to a great extent to the personal interpretation of the individual operator, thus seems unsatisfactory in comparison with the precise methods we are accustomed to expect in other present-day laboratory procedures.

There is no doubt that the determination of electrical excitability can give us information which can be gained in no other manner. It finds undisputed application in hysteria, cases of peripheral nerve injury, peripheral neuritis, and the various types of muscular atrophy and dystrophy, as well as in such conditions as myasthenia gravis and tetany.

With such a wide field of application, it was inevitable that technique should finally be advanced to a point where it was more adequate to meet the situation. The answer to the problem in this case was the application of chronaxia to the neurologic patient. The credit for this work belongs in a large measure to Bourguinon.[3]

PRINCIPLE OF CHRONAXIA

The principle of chronaxia (derived from the Greek *chronos,* "time") introduces the factor of the *time* during which the stimulating current acts, as well as the intensity of that current. The law of Du Bois-Reymond,[4] that the threshold of electrical excitability depended on the intensity of the stimulating current, but was independent of the length of time over which this current was allowed to act, was not successfully disputed until 1892, when Hoorweg,[5] by means of condenser discharges of very short duration, showed that intensities which would stimulate, when allowed to act over a considerable period, were ineffectual when their time of action was reduced to a few ten-thousandths of a second. Weiss,[6] in 1901, confirmed this, obtaining his current of short duration by an ingenious method whereby a pistol bullet was employed to close and open the circuit.

On the basis of this work, Lapicque[7] developed his concept of chronaxia as the length of time, expressed in thousandths of a second, over which a current of twice the rheobasic intensity must act to produce a reaction. The rheobase is the galvanic threshold when the current acts for an infinite period, which for practical purposes need not exceed one second. Working with isolated nerve muscle preparations, he found this value to be quite constant for the species and the anatomical location from which the specimen was obtained.

BOURGUINON APPARATUS

In 1916 Bourguinon overcame the technical difficulties of the application of Lapicque's apparatus and technique to the intact organism, and was able readily and accurately to determine the chronaxia of human nerve and muscle. Since that time there has been much work by Bourguinon and others in determining chronaxia both in normal and pathological states. Although chronaximetry has had a considerable vogue in the neurological centers of France and Germany, in this country it has but recently stepped from the physiological laboratory into the field of clinical neurology. It has the advantage over the older methods of determining the electrical reaction by making available a *quantitative* index of excitability, much less subject to the interpretation of the individual observer, and should thus overcome the main objections to the older methods.

The apparatus used by Bourguinon derives its currents of short duration from the discharge of condensers. The duration of the discharge of a condenser depends on two factors—the capacity of the condenser and the resistance of the circuit through which it discharges. By the employment of an ingenious system of high resistances in series and in parallel with the subject, it is possible to make the resistance of the discharge circuit practically constant, so that by varying the capacity of the condenser the duration of the current can be accurately controlled. Thus, the apparatus consists in essence of a source of direct current, derived from the ordinary house current after rectification and filtering, variable by means of a potentiometer from 0 to 300 volts. This current can be passed either through the discharge circuit directly, as in the determination of the rheobase, or utilized to charge a condenser of suitable capacity at twice the rheobasic voltage. This condenser is then discharged in the determination of the chronaxia.

In order to avoid polarization, the electrodes used are of the non-polarizable variety.[8] This is necessary because the sensitivity of the method would be impaired by polarization occurring with ordinary electrodes, which is not a significant factor with the grosser methods. The indifferent electrode consists of a sheet of silver, electrolytically covered with silver chlorid, 10 by 10 centimeters, applied by an elastic retainer to the subject's chest. The active electrode, which is the cathode, is a similarly treated silver disk, one square centimeter in area, mounted on a suitable handle. Both electrodes are kept moist by covering them with gauze saturated with physiological saline solution.

TECHNIQUE IN DETERMINATION OF CHRONAXIA

The determination of the chronaxia of a muscle is carried out as follows: the indifferent electrode is strapped to the subject's chest; with the active electrode the motor point is located. For this purpose the galvanic current is utilized, the circuit being made and broken by pressing knob *A* (see Fig. 1), while the intensity is controlled by turning knob *B*. When the motor point is found, the current is reduced by turning knob *B* to the left until a contraction can just be obtained. The voltage read on the voltmeter is the rheobasic voltage. The knob *B* is turned to the right until the voltmeter indicates double the rheobasic voltage, and the chronaxia is then determined by choosing a suitable condenser from the series controlled by

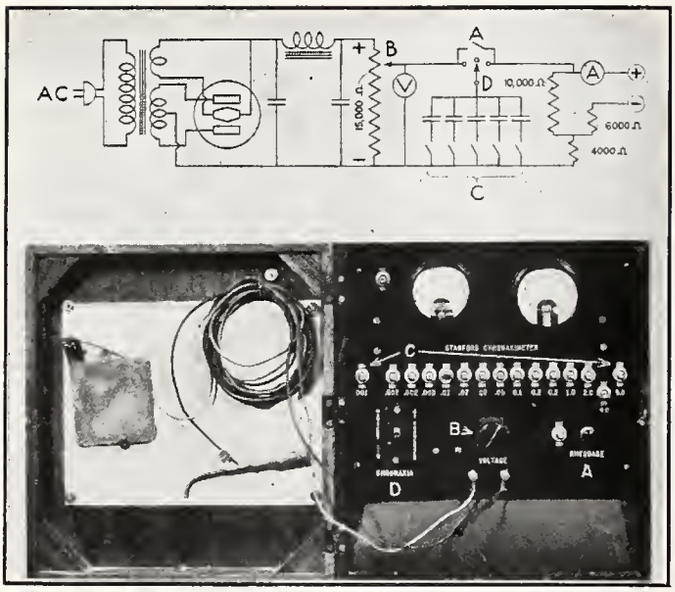


Fig. 1.—Portable Chronaximeter. (a) Rheobase switch. (b) Voltage regulator. (c) Condenser switches. (d) Chronaxia switch.

the bank of switches *C*, offering a continuous range of combinations from .001 to 11 microfarads; charging this condenser by throwing switch *D* upward, and then discharging the condenser through the subject by swinging switch *D* downward. The combination of condensers which will just produce a contraction is found by trial and error. This value in microfarads, as noted on the panel, is multiplied by Bourguinon's constant, 4, which gives the chronaxia of the muscle in sigma, or thousandths of a second.

Naturally, care must be exercised in the location of the motor point, as well as in the observation of the muscular contraction when the threshold is obtained. However, evaluation of the *speed and type of the contraction,* so important in the older methods, is here not essential, being merely confirmatory of the objective findings.

VALUES FOR VARIOUS MUSCLES

The values for various muscles in the normal have been carefully worked out by Bourguinon and others, and are remarkably constant from one individual to another. There is a fairly constant ratio of 2:1 between the muscles on the posterior aspect of an extremity and those on its anterior aspect, while the proximal segments of a limb have a shorter chronaxia than the distal segments. Thus Bourguinon gives the following values: for the proximal regions, the anterior muscles show a range from .06 to .14 sigma, the posterior from .16 to .34 sigma; for the distal regions the values for the anterior muscles are from .16 to .34 sigma, for the posterior group from .40 to .70 sigma. Thus, for practical purposes, *any value over one-thousandth of a second can be considered pathological.* In cases which show the complete reaction of degeneration by the older methods, the chronaxia is found to be from 10 to 30 sigma, while in the muscular dystrophies values up to 80 sigma may be characteristically encountered. Thus we see that the definitely abnormal values are so far removed from the normal range as to make their recognition certain; while, by this more precise method, changes may be recognized long before they would become apparent with the orthodox method.

An example of the evolution of a case of peripheral facial palsy of undetermined etiology is shown in Table 1.

REPORT OF CASE

A housewife, age forty years, presented herself at Stanford Clinic with the history and findings of a practically complete facial palsy on the left, of a week's duration. Chronaxia measurements were made at that time, and at intervals thereafter. It can be seen that at the first entry, although the clinical picture was fully developed, there was no alteration in the electrical reaction. Throughout, the chronaxia of the facial nerve itself did not increase significantly, but two weeks after the onset two representative muscles, the frontalis and the orbicularis oris, showed much increased values. The movement in the frontalis returned first, heralded by a decrease in the chronaxia of this muscle, which was later followed by the orbicularis oris. Thus, we see remarkably good correlation between the clinical improvement and the reversion of the chronaxia to nearly normal values.

SUMMARY

In summary, it may be said that chronaximetry (which has until recently been considered a procedure confined to the physiological laboratory), can be readily applied to the problems of clinical neurology, and promises to reëstablish the determination of electrical excitability in the position of importance which it deserves. It affords an easily obtainable index of the functional state of nerve and muscle which can be gained in no other manner, and provides a quantitative and objective measure of this functional state, which is not possible with the older methods of electrodiagnosis. Thus the determination of chronaxia is a valuable addition to the diagnostic and prognostic armamentarium of the clinical neurologist.

Stanford University School of Medicine.

TABLE 1.—*Time After Onset*

	One Week	Two Weeks	Three Weeks	Four Weeks	Six Weeks
Clinical course	Complete paralysis	Complete paralysis	Forehead improved	Mouth improved	Almost normal
Facial nerve	.28 sigma	.28 sigma	.8 sigma	1.2 sigma	1.2 sigma
Frontalis muscle	.28	12.0	6.0	1.2	.80
Orbicularis oris muscle	.60	9.2	8.8	6.8	1.0

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DISCUSSION

H. Douglas Eaton, M.D. (1136 West Sixth Street, Los Angeles).—There is no more important problem in neurology than the determination of the organic or functional character of a given condition. Accuracy in differentiation between a true organic nerve injury and an hysterical paralysis is not only of tremendous value to the patient, but may be of great economic importance. The ability to estimate the severity of an organic nerve injury, and to mathematically record its progress, endows us with real therapeutic insight. The development of a method giving an accurate quantitative valuation of muscle excitability promises to solve these problems for us, and to replace our present unreliable tests.

Doctor Newman's clear and concise article on chronaxia covers the subject completely. It is to be hoped that it will impress upon the general medical profession the fact that such a valuable diagnostic procedure is now practical and available.

❦

Samuel D. Ingham, M.D. (727 West Seventh Street, Los Angeles).—Doctor Newman has given a very good outline of the principles of chronaxia, and has demonstrated a simple and practical apparatus for its application. For a long time the practice of neurology has suffered from the lack of an exact method of testing motor responses to electrical stimulation to the nerve or directly to the muscle. Even to the present day the most modern textbooks on neurology describe the reactions of degeneration in terms of their response to the faradic and galvanic current. There has been no standardization of faradic coils, and the faradic currents from different instruments show wide variations in voltage and other qualities. Response in muscles from faradic stimulation is quantitative, with no index for measurement. When the galvanic current is used in testing degenerated nerves, the response is both quantitative and qualitative, but still we have no method for measuring the deviation from the normal response. In the chronaximeter we have an instrument by which electrical impulses can be applied to the nerve or the muscle from a series of graduated condensers. We thus have a graduated scale which is easily standardized and which permits a fair comparison of the results obtained by different observers. This method of examination is also sufficiently sensitive to make it useful in the study of motor responses in many conditions not due to primary disease of the nerves and muscles; as, for example, the effect of different drugs and different diseased conditions upon the responses of the neuromotor mechanisms.

❦

Robert Aird, M.D. (University of California Medical School, San Francisco).—In speaking of the clinical application of chronaxia, it is well to remember that this measurement of the electrical excitability of tissue is but one phase of the excitability of tissue in general. Other modes of excitation are possible, but the accuracy obtainable with the electrical methods as worked out by Lapicque and Bourguinon, make this method of particular value for the reasons stressed by Doctor Newman.

It is perhaps interesting to observe further that at the present time the principle of chronaxia is being studied more carefully in the laboratory. An ingenious young Englishman, Rushton, recently questioned Lapicque's concept of chronaxia. With carefully controlled studies, he apparently obtained varying chronaxia on the same tissues, the variation depending on the size of the electrodes. He concluded that chronaxia, as ordinarily measured, is not characteristic of the tissue alone, but of the tissue and electrodes. He also brought evidence to show that muscle has two characteristic chronaxia—one probably of the muscle fibers themselves, and the other apparently associated with the innervating nervous elements. This latter would seem to be the one principally involved in the clinical test over the "motor point" of the muscle.

Such facts, however, do not invalidate the practical clinical application of this concept, within the limits proposed by Doctor Newman. As he has stressed, it is undoubtedly a great refinement over the older method. In the hands of a well-trained neurologist, conscious of the possible errors in technique, this method should prove of considerable value over the older methods, both in the diagnosis of doubtful cases and in following the course of neurological cases from a neuromuscular standpoint.

BREECH EXTRACTIONS IN THE HOME*

By Bernard J. Hanley, M. D.
Los Angeles

Discussion *by Lyle G. McNeile, M. D., Los Angeles; Robert H. Fagan, M. D., Los Angeles; Sterling N. Pierce, M. D., Los Angeles.*

IN the period extending from June, 1929, to February, 1934, 5,805 women were delivered in their homes by Unit No. 1 of the Los Angeles Maternity Service. Breech presentations occurred 132 times, 2.3 per cent, which is slightly below the usual incidence. Of these 132 babies delivered, nineteen must be deducted for one or more of the following reasons; prematures, weighing less than three and one-half pounds (1,500 grams); macerated fetuses; monsters or deformities incompatible with life; and those in which the fetal heart was not heard during labor. Of the remaining 113 babies delivered, five were stillborn, or died during the neonatal period, a corrected mortality of 4.4 per cent. There were twenty-four primiparae, with one fetal death, a mortality of 4.1 per cent; and eighty-nine multiparae, with four fetal deaths, a mortality of 4.5 per cent. The average weight of the babies born of the primiparae was 6 pounds 9 ounces (2,950 grams), and of the multiparae 7 pounds 2 ounces (3,200 grams). A comparison of our fetal mortality, in breech presentations, with that of several other clinics is given in Table 1.

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

TABLE 1.—*Fetal Mortality in Breech Presentations*

Clinic	Cases	Fetal Deaths	Percentage	
Boston Lying-In	235	23	9.7	Corrected
New Orleans Maternity	159	16	10	Corrected
Chicago Lying-In	250	24	9.6	Uncorrected
Sloane Maternity	256	36	14	Uncorrected
Royal Victoria	114	6	5.2	Corrected
St. Louis Maternity	114	10	8.8	Corrected
Los Angeles Maternity Service	113	5	4.4	Corrected

It will be noted from this table that our corrected mortality is slightly lower than any other in this group, regardless of the fact that all of our patients were delivered in the homes.

MATERIAL IN THIS SURVEY

The Los Angeles Maternity Service gives prenatal and postnatal care to the indigents of Los Angeles City and County, and delivers patients in the homes of those residing within certain boundaries of the city limits. It is a teaching service. Residents are appointed for a six months' period, after having completed not less than a year rotating internship in an approved general hospital. All spontaneous deliveries are conducted by the residents, and all operative deliveries by the residents under the direction of one or more of the attending staff.

In this series, we are considering only those cases which were breech presentations at the onset of labor. The correct diagnosis was made prenatally in thirty-eight of these cases. Studdiford is of the opinion that the diagnosis of breech is missed in about 50 per cent of the cases. Although we see the patients every two weeks in the prenatal clinic, abdominal palpation is done only approximately every six weeks. This may account for such a small number being diagnosed prenatally. We do not attempt external version. McNeile feels that this is often a dangerous procedure, is usually ineffective, and should not be taught in a clinic, where medical students are always present.

The general policy in the Los Angeles Maternity Service is to hospitalize cases which show marked evidence of toxemia or hemorrhage in the last trimester. This results in some breech presentations being sent into the hospital which would otherwise be delivered in the district, and may account for our rather low incidence of breech presentation.

PROCEDURES IN BREECH PRESENTATIONS

When a patient is in labor, in which the resident makes a diagnosis of breech presentation, one of the attending staff is notified, and the patient is seen by him. If he confirms the diagnosis, the set-up for operative delivery is prepared. This is shown in Figure 1. We use the kitchen table for our operating table. The method of procedure then depends upon the type of breech presentation, and the progress of labor.

We classify breech presentations and define them as follows:

1. Frank breech: thighs are flexed on the abdomen and the legs extended on the chest, the feet lying along the head.

2. Complete breech: the thighs flexed on the abdomen and the legs flexed on the thighs and crossed, such that the buttocks and feet present simultaneously.

3. Footling: when one or both feet present at the internal os.

A frank breech, if engaged, is allowed to continue in labor until dilatation is complete, and the breech is on the perineum. With each pain, the breech is then guided until it is through the vulva and the lower extremities have been extracted. We then proceed with our extraction, as will be described under the method of breaking up a breech. If the breech is not engaged, and the membranes are ruptured, two hours are allowed after full dilatation, provided there is no fetal or maternal distress. If there is no progress, the patient is then deeply anesthetized with ether; the breech is broken up, and an extraction done. In breaking up a frank breech presentation, we have found Pinard's maneuver of the greatest advantage in getting both feet down. When both feet are delivered, traction is made in the axis of the birth canal until the breech sits in the hollow of the sacrum. Here we rest for a moment. The breech is then rotated, bringing the sacrum anterior. The sacrum is then covered with a sterile towel and grasped with both hands; traction is then made in the axis of the birth canal until the umbilicus is delivered through the vulva, at which time a ten-centimeter loop of cord is pulled down. The operator then continues traction, with a gentle spiral motion back and forth, until a scapula is fixed under the symphysis. The anterior arm is then extracted by gentle sweeping motion over the face and chest. The fetus is then rotated through 180 degrees, keeping the back anterior, and the second arm, which was posterior, is then brought under the symphysis and extracted in a manner similar to the first. The operator now introduces one hand into the birth canal and straddles the fetus over the same arm. Flexion of the head is increased by the introduction of two fingers into the baby's mouth. Suprapubic pressure is then made in the axis of the birth canal by the other hand of the operator. Two impor-



Fig. 1.—Photograph of operative set-up in home.

tant points are to be remembered at this time: First, the fingers in the baby's mouth are not for traction; second, the arm on which the baby is straddled is not to be raised so as to produce dangerous angulation. If undue resistance is met on the pelvic floor, an episiotomy is done and, if necessary, forceps applied on the after-coming head. It is our policy to explore the lower uterine segment and examine the cervix following a breech extraction in which there were any intrauterine manipulations.

In complete breech the same principles are employed as in a frank breech, except that when the breech comes on the perineum the feet are grasped and the extraction is done. This type of case is more favorable than the frank breech, because of the ease with which the feet can be grasped.

Footling presentations are the most difficult problems, because we are usually dealing with the undilated cervix, and we feel that the undilated cervix is a more common cause of difficulty in extraction than the bony pelvis. With one or both feet presenting, if the cervix is effaced and dilatable, we complete the dilatation manually, and do an extraction. If the cervix is not dilatable, the general policy would be to send the patient into the hospital for introduction of a bag.

FETAL DEATHS

In regard to our fetal deaths, there were two in which difficult deliveries were directly responsible.

REPORT OF CASES

Case 1 (No. 27610).—White, primipara, age seventeen, with a general contracted pelvis, frank breech presentation and membranes ruptured at the onset of labor. After thirty-six hours of labor, in which the cervix was fully dilated for two hours with no progress, the breech was broken up and a difficult extraction was done. Simpson forceps were used on the after-coming head. The baby, weight 9 pounds 2 ounces (4,100 grams), was stillborn. Autopsy showed a ruptured tentorium cerebelli, with considerable extravasation of blood.

* * *

Case 2 (No. 42637). — Mexican, age twenty-eight, para three, gravida 4; three spontaneous deliveries previously, with one stillborn baby. She had a general contracted pelvis, with a frank breech presentation. She was in labor eleven hours, in which the cervix was fully dilated for two hours, with the membranes ruptured, and no progress. The breech was then broken up and a difficult extraction done. An eight-pound (3,600 grams), stillborn baby was delivered. There was no autopsy.

We were unable to account for the fetal deaths in the remaining three cases, as the deliveries were not difficult. There were no autopsies, so the deaths must be charged against the method of delivery.

SUMMARY

A résumé of 113 breech extractions done on the Los Angeles Maternity Service is given.

There was a corrected fetal mortality of 4.4 per cent.

Breech presentations can be safely handled in the home, with no greater fetal mortality than in a hospital.

We feel that breech presentations should not be delivered by cesarean section until a thorough study of the pelvis has been made, and a disproportion shown to exist between the passage and the passenger.

The cervix must be fully dilated and paralyzed before attempting an extraction.

The extraction must be done slowly, and all well-established principles must be followed.

Forceps must always be available, in case of difficulty with the after-coming head.†

1930 Wilshire Boulevard.

DISCUSSION

Lyle G. McNeile, M. D. (523 West Sixth Street, Los Angeles).—There seems to be an almost irreducible minimum fetal mortality in breech deliveries of about 8 per cent, and this in clinics where the skill of the men working and the degree of intern supervision is at its maximum. The corrected mortality of 4.4 per cent on the Los Angeles Maternity Service is therefore remarkably low. There are two possible explanations. First, the policy practiced on the Maternity Service is that followed in the private practice of the men supervising these outpatient deliveries, *i. e.,* upon completion of dilatation, the breech is broken up and delivered. This, as we all know, is contrary to the usual teaching, and is no doubt open to criticism. However, in a large series of cases in private practice maternity service and the Los Angeles General Hospital services, we have concluded that this method in the hands of the trained obstetrician gives the best results. We have never taught this as a practice for the general practitioner without special obstetrical training. Second, the supervisors of the Maternity Service never hesitate to deprive the outpatient staff of deliveries when the question of safety for mother and baby arises; and cases are occasionally hospitalized, that might subsequently have raised our fetal mortality if delivered in the home. I refer particularly to the footling presentation in primipara in which dilatation is incomplete after a prolonged first stage and in which the cervix is of such consistency that it seems better to insert a complete dilatation bag. We believe that the cervix is the most frequent cause of infant mortality in breech deliveries.

Complete dilatation of the cervix, deep anesthesia and an unhurried rigid adherence to correct technique, with a complete understanding of the obstetrical anatomy of the pelvis and the mechanism of breech labor, are the fundamentals that lower fetal mortality in breech extraction.

† The author wishes to thank Dr. Lyle G. McNeile, director of the Los Angeles Maternity Service, for permission to use the records, and his colleagues, Dr. Philip A. Reynolds and Dr. R. D. McBurney, for their assistance in a number of cases here reported.

Robert H. Fagan, M. D. (1136 West Sixth Street, Los Angeles).—The technique described for breech extractions by Doctor Hanley is, in my estimation, the safest of all procedures which have been described for this operation. Of all obstetrical procedures, I believe that the breech extraction is the most feared and the least understood by many physicians. Doctor Hanley's low fetal mortality rate is certainly worthy of comment. Particularly is this true when one considers that these deliveries were executed by many individuals in the process of their obstetrical training. It is doubtful if an obstetrician in private practice has as remarkably low fetal mortality rate in his breech deliveries. I should like to ask if many of the breech presentations are hospitalized for delivery? If so, it would be interesting to compare the mortality rate of those delivered in the hospital and in the home.

Sterling N. Pierce, M. D. (1930 Wilshire Boulevard, Los Angeles).—In this series of breech presentations, which were delivered on the City Maternity Service of Los Angeles and reported by Doctor Hanley, we are shown a mortality rate which is indeed very low, in fact, the lowest to be reported in six of the outstanding clinics of this country and Canada. It must be remembered that our City Maternity Clinic is strictly a teaching service, where training is given residents and medical students. This report shows the painstaking way with which the Service has been supervised.

There is little to add to what Doctor Hanley has said, but some points should be particularly stressed. First, in the handling of any breech delivery, the operator must be able to evaluate the comparative size of the passage and the passenger, for a successful delivery from below. Second, that a woman in labor with a breech presentation requires the same careful watching as a vertex presentation. Both mother and babe should be observed closely with no interference so long as labor progresses favorably. By no interference, we mean that the B. O. W. be kept intact, if possible, until dilatation of the cervix is complete.

Complete dilatation, or its equivalent, is essential before any breech extraction is attempted. In cases when the condition of either the mother or the baby indicates immediate delivery, one should resort to either mechanical means of dilating the cervix, or incisions.

Doctor Hanley also stresses the fact that a breech presentation should be allowed to progress normally until the lower extremities have been delivered. His method of delivery is worthy of careful study, particularly the extraction of the arms; since, although contrary to textbook teachings, it will cause less injury to the arms. Stress is also laid on the method of handling the after-coming head; namely, the head is maintained in flexion by inserting the fingers in the baby's mouth, and delivering the head by making pressure from above. Forceps on the after-coming head is a safer procedure, if any resistance is met at the bony pelvis.

However, it is my belief that episiotomy should be a routine procedure in primiparae. Another very important point which few understand is that time is not a particular element in breech extraction. Many babies have been lost or seriously injured by the operator endeavoring to complete delivery in a certain allotted time. While a breech should be delivered as rapidly as possible, gentleness and art are the first principles to be considered.

When we consider that this series was delivered on the old kitchen table on a teaching service, I feel that Doctor Hanley has contributed a great deal, particularly in showing the profession that every breech presentation is not necessarily an indication for abdominal delivery.

CALIFORNIA MEDICAL-ECONOMIC SURVEY*

EXCERPTS FROM THE PRELIMINARY REPORT OF JANUARY 16, 1935

PURPOSE AND SCOPE OF THE STUDY

WHEN the staff of the California Medical-Economic Survey took up duties last August, it outlined a fourfold purpose of the research work to be undertaken. The staff proposed:

1. To ascertain the amount paid by various classes of income receivers in California for medical and dental care.
2. To determine the ability of various income groups in California
 (*a*) To pay for health and dental services.
 (*b*) To secure adequate medical and dental care.
3. To review methods of meeting the problem of medical care in various localities within the State, in other states, and in other countries.
4. Finally, after various methods of meeting the problem of medical care elsewhere have been reviewed,
 (*a*) To set forth all possible alternative methods of meeting such problems as the survey reveals exist within the State, and
 (*b*) To make constructive proposals based upon the findings of this study.

Almost five months have elapsed since this outline of study was made, and in view of the pressure of interest and developments the field to which the study pertains, it is quite appropriate and necessary for a pause to be made during which time the staff can summarize its activities and accomplishments to date, and present several significant preliminary findings together with appropriate recommendations.

The objectives to which the staff is committed necessitate very extensive investigation and study. A mass of data has been gathered in the last few months, but the work of tabulation and analysis only began recently. It is therefore necessary to emphasize that the tables presented in this Pre-

*Editor's Note.—The House of Delegates of the California Medical Association, at the annual session held at Riverside, in April, 1934, authorized the appointment of a special Committee of Five for the Study of Medical Care, and instructed it to make a medical-economic survey of California. This committee appointed consisted of Doctors William R. Molony, Chairman, Los Angeles; Harry H. Wilson, Secretary, Los Angeles; Alson R. Kilgore, San Francisco; Robert A. Peers, Colfax, and Rodney A. Yoell, San Francisco.

Paul A. Dodd, Ph. D., Assistant Professor of Economics in the University of California at Los Angeles, was appointed director of the survey; and Gordon S. Watkins, Ph. D., also Professor of Economics in the same university, was made consulting economist.

An Advisory Council, as well, was provided for, made up as follows: John B. Canning, Ph. D., Professor of Economics, Stanford University; Arthur G. Coons, Ph. D., Dean of Men and Associate Professor of Economics, Occidental College; Rockwell D. Hunt, Ph. D., Dean of the Graduate School, University of Southern California; The Reverend James J. Lyons, S. J., President of the University of Santa Clara; and Samuel C. May, Ph. D., Professor of Political Science and Director of the Bureau of Public Administration, University of California. At the same time, offices in which the administrative work could be carried on were established at the Beverly Professional Building, 9625 Brighton Way, Beverly Hills, California.

On January 16, 1935, Director of Survey Dodd submitted to the Committee of Five a Preliminary Report of 91 typewritten pages, copies of which were sent to the officers and component county societies of the California Medical Association, and to the delegates who were called in special session at Los Angeles on March 2 and 3. Later a Supplementary Report of some 30 pages was issued. Some excerpts from the first report are printed on this and the following pages, and to these extracts the attention of members of the Association is called, in connection with the reports adopted at the special session of the House of Delegates on March 3, 1935, as presented on page 194.

The excerpts printed under the starred title are from a report by Director Dodd's Survey Staff to the Committee of Five.

liminary Report are subject to later modifications. The labor involved in this type of work is far more extensive than at first might be realized; and adequate final analysis is dependent upon sufficient time and financial resources. With this warning in mind we turn first to a review of the research staff's activities and accomplishments up to the present, and an outline of tentative plans for the scope of the final study.

The field survey phase of the staff's study has been limited to the State of California; but the broader economic aspects of the problem of medical and dental care, involving a study of methods and principles, has been unlimited in scope. Thus, the factual data relating to the health and economic conditions of families, to doctors, dentists, hospitals, clinics, etc., have been purposely limited (in the main) to individuals and organizations within the State. But, on the other hand, all the data and information relating to methods of meeting public or private health needs have been secured wherever such information has been available. In other words, the statistical picture presented is one of conditions existing within California, while the results of experience and experiment elsewhere have been studied wherever it has been possible to secure records of them.

TYPE OF DATA BEING GATHERED

The study is being based upon two types of data. One is composed of schedules[1] calling for information from the public and from the various professional groups and institutions related to the broad fields of medicine and dentistry. Two forms of general schedules have been used in recording information from the consumers of medical and dental services: the first for use by field visitors in personal contact with the individual family, and the second for use by the family indirectly through the mails or through some representative organization. Upon these two forms information has been obtained concerning the economic and health conditions (such as income, principal ailments, treatment, expenditures, etc.) of families throughout the State.

In addition to these general schedules for the public, a carefully planned schedule was constructed for recording data to be secured from the doctors, another for the dentists, another for the hospitals of the State, and still another for clinics.

All of these schedules were drawn up with the greatest possible care. Each form was compared with those used previously in similar studies; each was submitted to its respective group of doctors, dentists, hospital executives, or clinic heads for criticisms and suggestions. Furthermore, these forms were submitted also to each member of the Advisory Council and to the statistical research departments of both the State and the Federal Emergency Relief Administration. Thus, they were finally approved by these qualified individuals before being adopted by the staff for actual use. It might also be added that in the case of the general schedule actual sample test runs were made in the field before the final forms were printed so that as many of the indefinite questions as possible might be omitted, and proper final revisions might be made before the forms were put to final use.[2] But still several advisable alterations escaped the attention of the staff, not to be discovered until the field work was almost completed. No doubt a similar test run on the other forms would have proved valuable in indicating the desirability of changing the wording of several questions, and dropping several others from the forms. But in general they would have remained essentially the same. Certain obvious omissions of questions from the general schedule have been made deliberately, in order to minimize duplications and coördinate the information requested on the staff's schedules with that obtained by other studies of a somewhat similar nature.[3]

The second type of material being collected is composed of information relating to other phases of the problem of medical-economics, such as the details of hospitalization plans, health insurance plans, expressions of opinion from individuals and organizations, research material from other studies, the original questionnaires used in previous surveys, information from public health agencies, and insurance companies. This material, the staff feels, is needed for proper evaluation and interpretation. While this list of the material being used is not complete, it may serve to indicate the type of data on which the staff is working.

GENERAL SCHEDULES SENT OUT

The intensive research program suggested above has necessitated a scientific method of procedure and as effective an administrative organization as possible to make certain that such a procedure was being followed. The first step, it was felt, was concerned with the selection of sampling areas throughout the State for use of the general schedule. The staff believed that if a one per cent random sample were obtained from the family population of the State, a picture gained from such a sample would be representative of the State as a whole; and if carefully taken would be acceptable for the purposes of this study.

An application for a blanket grant from the State Emergency Relief Administration to aid in the undertaking of this work throughout the State would have called for the establishment of a new precedent which would have set aside individual county autonomy in the handling of appropriations. This was found to be inadvisable and impracticable, and a different procedure for the organization of the field work of the survey was adopted. Under this new plan the State was di-

[1] The forms used in this study are referred to as "schedules" rather than "questionnaires"—the distinction being principally one of set-up. A schedule is usually formidable in appearance, asking for much of the information to be filled out in tabular form; while a questionnaire is usually made up of simple questions calling for short and positive or negative answers.

[2] Copies of all forms used will be incorporated in the Final Report.

[3] It was particularly important to coördinate the work of this study with that of the depression and health survey (a California study being made under the direction of Miss Margaret Klem). Such questions as those relating to the division of medical and dental payments were omitted from our schedules because this information was being obtained in Miss Klem's study.

vided into counties, and an organization for the California Medical-Economic Survey was set up in each county included in the program. The staff recognized that the value of any survey which utilizes the principle of random sampling depends directly upon the care exercised in planning and executing the sampling process, and it has made every effort to develop a method of selecting sample families which, while being as simple and objective as possible, would still constitute a representative and unbiased cross section of the families throughout the State. In order to be doubly certain that this representative sample was being obtained, classifications permitting a close comparison of the staff's figures with those of the United States Census Bureau have been followed.

For the field work on the general schedule, then, the primary division of areas (for the purpose of sampling) was according to rural or urban residence of the family. Then followed the classifications of race and occupations. When these three items were taken into consideration, the sampling process became essentially a matter of geographical subdivision according to population densities. Since a one per cent random sample was desired, the best way to obtain this sample would have been to secure a one per cent sample from every town and village, and from each small unit of rural section in every county of the State. As indicated above, however, this was impossible for obvious reasons.[4] Instead, a selection of certain towns and villages and rural districts having geographic, economic, racial, and occupational characteristics quite representative of the county as a whole was made in twenty-six of the fifty-eight counties throughout the State.[5] Field work was thus concentrated in certain parts of the twenty-six counties covered, these counties in turn representing a total of almost 94 per cent of the population (1930) of the State.

SUMMARY OF FIELD ACTIVITIES

Reference to the field activities will show that a total of 682 workers was engaged for the field work throughout the State, and that seventy-five have been employed in the central office on relief work. Of the 682 employed to carry on field operations, twenty-nine were supervisors, forty-three were office stenographers, local editors, and clerks; and 610 were field visitors. Some difficulties were encountered in the selection and training of such a large staff in a short time.[6] The fact that every field visitor engaged was limited to a work-relief budget and was paid by the Relief Administration created many difficulties in regard to the selection and qualifications of field personnel. In some counties, as in San Francisco, it was necessary to limit the time each worker spent in the field on the survey to only one or two days each week in order to comply with the regulations of the County Relief Administration. In San Diego County, on the other hand, field visitors were allowed anywhere between fifty and one hundred hours of work per month. This permitted one group of workers to complete the whole survey in that county. In Los Angeles County, after the county officials had granted a special request of the staff, the field visitors were allowed to work out (without restriction as to the maximum number of hours per day or days per week) their total monthly work order budget consecutively and without interruption. Nevertheless, in Los Angeles County a total of 297 field visitors were selected and trained to do the work originally planned for about 135 full-time workers. This was made necessary, as indicated above, because of the limited work allowances made to the State Emergency Relief workers during any one month.

Only a few of the problems bearing upon the field work of the survey have been indicated here. In view of the large labor turnover, the rapidity with which the survey organization has been built up, and the extent of the territory over which it has been spread, the accuracy of the results obtained may be questioned by some. A defense does not fall within the bounds of this brief preliminary report, and yet the staff feels that such a criticism is serious enough at least to be recognized. Suffice it to state here that all of these matters have received the closest scrutiny of the staff; and that while they may be serious, enough precautionary measures have been taken in advance to enable them to be dealt with satisfactorily. A system of rechecks has been developed so that each schedule filled out in the field has been edited by the county supervisor or his assistant before being turned in at the central office, where it has been double-checked completely by two different editors. Again, the accuracy with which the individual workers have obtained information is being checked by revisits to a number of the families originally giving the information. These and other rechecks have disclosed a number of inaccurate schedules, but the thorough application of the rechecks should permit the reliability and accuracy of the final results to be accepted without serious question.

However exhaustive the staff's efforts may be in rechecking, careful examination has demonstrated that information presented in answer to several questions on the schedules, at best, is only a guess on the part of a majority of the informants. Information of this quality, therefore, must be omitted from tabulations and analysis. This is particularly true of information concerning the family budget, where editing has shown that not more than one or two families out of one hundred keep a budget accurately enough to give proper proportional expenditures. Schedule returns from doctors, dentists, hospitals, and clinics have also disclosed several questions, answers to which cannot be tabulated for the same reasons. The staff mentions these cases only for the sake of emphasizing the care with which final interpretations are to be made.

4 The cost of securing the sample in some of the more inaccessible counties would have proved to be prohibitive. The primary consideration, however, in including any county in the survey was not one of cost, but rather one of population and representativeness.

5 For list of counties covered, see Appendix.

6 The duration of field work has ranged from ten days in Imperial County to ten weeks in Los Angeles County, depending upon the size and population of the county in question.

SCHEDULES MAILED OUT

A second set of primary data has been obtained in answer to schedules sent out through the mails. A glance at the table below will indicate the extensiveness of this program.

TABLE 1.—*Summary of Schedules Mailed Out (to January 1, 1935)*

Mailing	M.D.	D.D.S.	D.O.	Hospitals	Clinic	Total
Original	9,236	5,669	1,314	460	416	17,095
First follow-up	7,240	5,056	1,070	433	300	14,099
Second follow-up	6,700	4,230		300		11,230
Total	23,176	14,955	2,384	1,193	716	42,424

Every person whose name appears in the March, 1934, Roster of Physicians and Surgeons, and in the September, 1933, Dentists' Directory, as well as every hospital and clinic throughout California, was solicited by means of a form letter with an enclosed original schedule. After an adequate waiting period, a first follow-up was addressed to those who had not returned a card stating that a schedule under separate cover had been filled out and mailed to the office of the survey. Where the staff felt it advisable, a second follow-up was sent out. When the coöperation of professional associations was lent, misunderstandings in regard to the purpose of the survey were cleared away, and thus the number of follow-ups that it was found necessary to send out was reduced considerably.

In addition to the mailing program indicated in the table above, the staff had printed a total of 26,000 direct mailing schedules which have been or are being distributed by three methods to individual families. Part of these schedules were stamped and addressed to certain mail-carrier routes in selected city districts and inaccessible villages not covered by field visitors. Another portion was sent out through unstamped personal deliveries made by field workers in metropolitan districts of Los Angeles and San Francisco not covered by the regular field visitors. The remaining portion is being distributed to members of the Parent-Teachers Association through officials of the various association units. This work is frankly admitted to be experimental, and while the returns are being tabulated separately from the other schedules, the staff feels that the checking made possible in this way more than justifies the relatively small additional expenditure involved in having these forms printed and distributed.

Many other inquiries have, in the course of this investigation, been addressed to groups such as the county health officers, presidents of civic organizations, representatives of commercial and labor organizations, employers, and others.

RESULTS OF THE SURVEY

At this early stage, a brief presentation of some of the data made available by the survey is all that can be attempted. The following tables show the total number of responses received and compares the percentage of responses in this study with those obtained in previous surveys.

TABLE 2.—*Summary of Schedule Receipts (to January 12, 1935)*

Schedules Received	Complete	Incomplete	Total
General schedules from field visitors	19,601	609	20,210
General schedules through mail	1,157	25	1,182
Doctor schedules—M.D.	3,112	296	3,408
Doctor schedules—D.O.	646	59	705
Dentist schedules—D.D.S.	1,828	85	1,913
Hospital schedules	192	33	225
Clinic schedules	97	49	146
*Total	26,633	1,156	27,789

*Incomplete schedules are here classified as those having practically no information in usable form on them. Thus the number classified as complete will actually be less, considerably so in some cases, where tabulations on the answers to specific questions are being run, and the number included in the total tabulations of questions will vary according to the completeness of the answers to individual schedules.

From a study of the table below, it will be noted that, to date, 34 per cent of the doctors of medicine communicated with have sent in a fairly complete answer. When the total returns including

TABLE 3.—*Percentage Replies in California Medical Economic Survey Up to January 12, 1935*

Classifications	Number in California Originally Contacted	Complete Schedules Received Number	Complete Schedules Received Per Cent Replying
M. D.	9,236	3,112	34
D. O.	1,314	646	49
D. D. S.	5,669	1,828	31
Hospital	460	192	42
Clinic	416	97	23

296 incomplete schedules are counted in, this percentage is increased to thirty-seven. In the two surveys made by the Committee on the Costs of Medical Care (with the coöperation of the American Medical Association), a total of approximately 40 per cent of the doctors of medicine finally responded;[8] while in the Michigan study approximately 50 per cent responded,[9] and in the Tacoma, Washington, study to date a total of about 25 per cent have replied. It should be added that the 34 per cent response here referred to is based upon the total number of doctors of medicine listed in the Directory of the Board of Medical Examiners (1934), supplemented with an up-to-date list of those licensed by the board on or before April 1, 1934. Judging from replies explaining why schedules are not being returned, these lists have contained hundreds of names of doctors of medicine who have retired from active practice. If this is true the real percentage return increases accordingly.

It might be interesting in passing to note that the 31 per cent response from the dentists received from various parts of the State compares with a 62 per cent reply received in answer to a questionnaire sent out in 1930 by the American Dental Association. These forms were sent out to a one-in-four random sample from an alpha-

8 Maurice Leven, *The Incomes of Physicians*, Chicago, University of Chicago Press, 1932, Chapter II.

9 Michigan State Medical Society, *Report of the Committee on Survey of Medical Services and Health Agencies*, 1933, page 69, and Chapter IV.

10 From a special communication concerning the survey being conducted by the Foundation for Social Research in Medical Care in Tacoma, Washington, of which John Schlarb, Jr., is director.

betized list of 35,700 names.[11] However, returns from all groups covered by the California Medical-Economic Survey are still being received, so these percentages should not be accepted as final. Even so, the returns received to date appear to be entirely adequate and representative of the various professions and groups concerned.

FINANCIAL APPROPRIATIONS

The detailed work of coding, editing, and punching is progressing satisfactorily, and there still remains a sufficient balance from appropriations of the State Emergency Relief Administration to see this work properly completed. For a summary of information concerning appropriations both from the Relief Administration and from the sponsors of the survey, reference is here made to the financial summary presented at the end of this report. It will be noted that total appropriations of some $55,425.42 have been secured from the State Emergency Relief Administration (through coöperation of the California State Board of Health), and expenses amounting to approximately $17,260.35 for proper direction[12] and $11,382.96 for supplies and staff overhead expenses are being met mainly by the California Medical Association. Within the last three weeks the California Medical Association has approved an additional request for approximately $5,000, and the Los Angeles County Relief Administration has approved one for $6,270. This has been done in order to permit the proper and thorough completion of the field and research work. These Relief Administration grants, together with the extensions of appropriations from the California Medical Association, are making possible a far more comprehensive and complete final report than was originally planned.

PLANS FOR COMPLETING THE FINAL REPORT

It is hoped that the brief sketch contained in the preceding pages may serve to emphasize the fact that the work of the staff is still far from complete. A volume of factual data now lies in the central office of the survey, where it awaits accurate classification and correlation before complete analyses and interpretations can be made. In fact the data attached to this Preliminary Report, it must be remembered, constitute only a very limited sample of what can be compiled from the schedules and other data already available. In interpreting this material the members of the staff plan to make thorough tests of reliability and frequent comparisons between the results of this study and the results of others previously completed. At the same time, they are not unmindful of the qualifications that must be attached even to the final results. Work toward its completion is being hastened as fast as accuracy and thoroughness permit, and should end some time this spring.

11 The American Medical Association list was composed of 8,923 names selected by taking every fourth name appearing. Usable data with respect to incomes were supplied by 59 per cent of the total number communicated with. See Maurice Leven, *The Practice of Dentistry and the Incomes of Dentists in Twenty States, 1929*, Chicago, University of Chicago Press, 1932.

12 This includes payroll needs for twenty-four full-time workers and nine part-time workers during the peak of the field work in November and December.

PURPOSE OF PRELIMINARY REPORT

Before turning to the two main divisions of the report that follow, it might be well to summarize the objectives of the Preliminary Report. They are, briefly, four in number, the first of which has been briefly covered in this Introduction:

1. To review the staff's activities, summarizing the results to date and indicating the scope of the Final Report.
2. To present and explain some significant preliminary tabulations (Part II).
3. To review briefly some of the more important principles and methods of health insurance (Part III).
4. To set forth certain qualified conclusions and recommendations, pending the completion of the Final Report (Part IV).

It is hoped that the foregoing discussion will have made clear the limitations of this Preliminary Report due to the incompleteness of the data incorporated in it and the fact that more time is required to enable a complete analysis of all the data to be made and final conclusions to be reached. In spite of these limitations the trends or tendencies revealed, even in this report, are not without significance.

* * *

SELECTED FACTS FROM THE REPORT

Thirty per cent of the population of California live on farms or in communities of less than 5,000 inhabitants.

California had, in 1927, a higher proportion of physicians to population than any other state in the United States, or any nation in the world.

In California, in 1934, there were 537 persons per doctor of medicine in six metropolitan counties, while for the State as a whole, there were 625 persons per doctor of medicine.

In 1934 doctors of medicine in the State were almost twice as numerous as dentists, three times as numerous as chiropractors, and seven times as numerous as doctors of osteopathy.

The proportion of practitioners in Los Angeles in 1934 was four times as great as in communities of less than 5,000.

Over 40 per cent of all practitioners in Los Angeles and San Francisco are doctors of medicine, and almost 25 per cent are dentists.

Rural areas including small urban centers have a greater hospital bed capacity in proportion to population than have urbanized communities.

Patients with ordinary illnesses, requiring the facilities of general, maternity and children's hospitals, have access to only half the hospital bed capacity of the State.

Three hundred and ninety-nine hospitals reported a total bed capacity in 1933 of 61,053 beds, admitted 520,991 patients during the year, and had an average occupancy of 48,017 patients.

In 1933 all hospitals in California operated at about 79 per cent capacity. Government-owned hospitals operated at almost 90 per cent capacity, and non-government-owned operated at 53 per cent capacity.

The bed capacity of non-government-owned hospitals declined slightly from 17,362 in 1933 to 17,345 in 1934, while the bed capacity of government-owned hospitals increased from 43,691 in 1933 to 46,181 in 1934.

The number of patients admitted to non-government-owned hospitals in 1933 was almost as large as the number admitted to government-owned, while the bed capacity was less than half as large.

Almost one-third of the doctors of medicine earned less than $2,000 in 1933. Half of them earned less than $3,000, and three-fourths less than $5,000.

Approximately half the doctors of medicine reporting for both 1929 and 1933 earned less than $6,000 in 1929, while three-fourths earned less than $6,000 in 1933. Twenty-five per cent earned over $9,000 in 1929 and only 10 per cent in 1933.*

In 1933 one-half of the osteopaths had incomes of less than $2,000. Eighty-six per cent of them earned less than $4,000.

Five per cent of the doctors of osteopathy earned over $10,000 in 1929. None were in this income class in 1933. Fifty-one per cent of the osteopaths in 1929, and 85 per cent in 1933, earned less than $4,000.

Dentists appear to have earned less than doctors of medicine but more than osteopaths, in both 1929 and 1933.

In 1933, 34 per cent of the dentists earned less than $2,000, 61 per cent earned less than $3,000, and 78 per cent earned less than $4,000.

Only 13 per cent of the dentists reporting incomes for both 1929 and 1933 earned less than $2,000 in 1929; but in 1933, the proportion was 30 per cent. Forty-four per cent earned less than $4,000 in 1929, as compared with 76 per cent in 1933.

The depression seems to have affected the incomes of dentists and osteopaths more than those of doctors of medicine.

Eighty-one per cent of the 4,882 families upon which information has been tabulated reported annual incomes in 1933 of less than $2,000. Of these 26 per cent had incomes ranging from $2,000 to $1,200, and 55 per cent had incomes of less than $1,200.

Out of the 19 per cent of families found to have incomes of over $2,000 in 1933, 11 per cent had incomes ranging from $2,000 to $3,000, 5 per cent had from $3,000 to $5,000, and nearly 3 per cent had incomes of $5,000 and over.

Of all persons in the income class under $1,200, 17.3 per cent required medical attention in contrast to the 8.6 per cent of persons in the income class of $5,000 and over.

No significant differences in the need for medical care appear among the income classes between $1,200 and $5,000. The proportion of persons needing medical attention who received a diagnosis is smallest in the low income classes and greatest in the high income classes.

Twelve and three-tenths per cent of all persons in the income class under $1,200 were reported as requiring dental attention against 4.4 per cent in the class of $5,000 and over.

The proportion of persons needing dental attention who received a diagnosis varies with income, and relatively more sharply so than those reporting a need for medical attention who received a diagnosis.

Only 21.2 per cent of the income class under $1,200 needing dental attention were receiving it, while 60.3 per cent of those in the $3,000 to $5,000 class who reported the need for treatment were receiving it.

Twenty-five and seven-tenths per cent of all families studied reported no medical and dental charges had been incurred within the period September 1, 1933, to September 1, 1934. This does not necessarily mean, however, that they were receiving no medical care, for some may have received free clinical attention or free services from members of the professions.

The proportion of families reporting no charges incurred during a one-year period varies from 33.4 per cent in the group under $1,200, to 10.4 per cent in the group of $5,000 and over.

In each income class there are both large groups of families experiencing high charges and large groups experiencing low charges.

Of the families receiving less than $1,200 in 1933, 15 per cent reported that charges ranged between $20 and $40; 8 per cent reported charges of $100 to $200; 3.8 per cent or 103 families reported charges of between $200 and $500; twenty-three families reported charges between $500 and $1,000, and nine families reported charges of over $1,000.

Medical charges amounted to a proportion varying from half to all of the reported income of thirty-two of the families incurring charges of over $500. Of the families reporting incomes in 1933 ranging from $1,200 to $2,000, 15 per cent reported medical and dental charges from $100 to $200, while another 8 per cent reported charges of from $200 to $500.

In the income group between $2,000 and $3,000, 19 per cent of the families incurred charges between $100 and $200, and 14 per cent incurred charges between $200 and $500.

A great variety of health insurance schemes exist in various parts of the world. These include voluntary, semi-voluntary and obligatory plans.

The general tendency in recent years has been towards the extension of obligatory health insurance schemes in areas where they already existed, and the adoption of obligatory schemes in areas where previously only voluntary or semi-voluntary schemes had existed. This tendency has been slightly checked in some areas by the financial difficulties associated with the present economic depression.

The survey reveals defects in the existing organization of medical and dental services in California. A study of different systems of health insurance reveals the existence of defects in all of them.

Perfection is unattainable. The merits and defects of existing arrangements have to be compared carefully with the merits and defects of alternative arrangements.

* Editor's Note.—Income figures given are net. The Final Report, based on a larger number of replies, may show variations from figures here printed.

PSYCHOTHERAPY*

By George S. Johnson, M. D.
San Francisco

Discussion *by H. Douglas Eaton, Los Angeles; Clifford W. Mack, M. D., Livermore; Thomas G. Inman, M. D., San Francisco.*

IT is frequently asserted that psychotherapy is the oldest form of medical treatment. The inference might be drawn therefrom that in such an old and well-established practice, a review of its various techniques at the present time might be superfluous. However, there has arisen a situation in the general field of medicine that makes a consideration of psychotherapy peculiarly opportune.

THE SCIENTIFIC METHOD OF APPROACH IN MEDICINE

With the advent of the scientific method, and with its application to the field of medicine, there has developed a point of view that emphasizes, almost to the exclusion of others, the objective attitude toward the problems encountered. The essential character of science is not in the nature of the facts with which it deals, but in the method of attack which it employs. This method consists in the well known formula of, first, the observation of phenomena; second, the orderly arrangement and classification of the facts which have been observed; and, third, the finding of laws which will serve to explain those facts, and enable

* From the Department of Neuropsychiatry, University of Stanford School of Medicine.

Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

us to predict and control the occurrence of future phenomena of the same order.

This method as applied to medicine has radically altered the entire discipline. The study of physiology has developed from a relatively simple investigation of the functions of the living organism into an elaborate search for the ultimate in living processes as expressed in the function of detachable parts. This has led to the erection of bigger and better laboratories, in which may be studied the finer details by physical, physicochemical, and biochemical means. Pathology has become concerned not only with the microscopical study of diseased cells, but it goes further into the ultra-microscopic interpretation of intracellular relationships. Bacteriology is no longer content to identify certain organisms, but must identify the subtypes and their variations. The pursuit of these and similar studies has had the tendency to emphasize the importance of the various phenomena to the exclusion of a consideration of the patient. While these studies have contributed immeasurably to the understanding of disease and disease processes, they have not added much to our understanding of the total patient. We have attained a place in the practice of medicine where, despite the possession of more exact methods of diagnosis and more complete knowledge of the nature of disease than ever before, we find physicians asserting that they are unable to treat from 40 to 50 per cent of their patients because they are "psychoneurotics," or admitting that, in their treatment, they are not giving the patient what he thinks he is getting or what he is paying for.

PSYCHIATRY'S CONTRIBUTION

If this be true—and statements made by professors of medicine throughout the country in a recent survey indicate that it is true—what has psychiatry to contribute at the present time for the relief of this situation? In the first place, it should contribute a point of view. Sound psychotherapy presupposes a knowledge of what constitutes normal behavior. As indicated by the prevailing trends in psychiatric education, this knowledge is embraced in the subject-matter designated by various names, but most commonly as psychobiology, a term introduced by Adolf Meyer. "Psychobiology," says Doctor Meyer,[1] "starts not from a 'mind' and a 'body,' but from the fact that we deal with persons as biologically organized units and groups, behaving in more or less definable situations. It studies chiefly others and ourselves, very much as we study others. It occupies itself with a 'body in action,' as far as we are able to denote behavior and function of that entity best described by the terms 'he' or 'she.' We are aware of a contrast between the activity of detached or detachable organs, such as the heart or the stomach or the brain, and the activity of these same parts when functioning as part of the 'he' or 'she,' or 'you' or 'I,' that is, units with subject organization and personality function. It is behavior, overt and internal, or implicit, as far as the organisms or person works as the 'he' or 'she' that concerns us. What we study as behavior naturally goes far beyond what we can read off from the dead body; we have to deal with the live organism in action, as behavior or ergasia in the process of life situations or life developments. There need be neither a neurological dilemma nor a philosophical one. There is a natural place for a psychobiology treating all the facts constituting man's behavior as a person—without a separation of mind and body, but as a biologically integrated organism in his natural attitude reaction or action, the material of a person's life record. It cultivates the habit of singling out what plays a vital rôle, in terms of specific experiments of nature, the conditions under which it occurs, the factors that enter into it when working, their results and their modifiability; in other words, a genetic-dynamic distributive analysis and synthesis."

PSYCHOPATHOLOGY

Such a concept of behavior furnishes a sound foundation upon which to build an understanding of the deviations of behavior which are found in the various categories of mental disease. This understanding is considered under the general heading of "psychopathology." This "science," which attempts to explain the problems of mental disorder by psychological principles and laws, has had a remarkable advancement through the work of various schools. Developing upon the background provided by Mesmer with his magnetizers, Braid with his hypnotisms, Charcot with his suggestion and hypnosis, Dubois with his persuasion, and followed by Freud and the psycho-analytic school, there has arisen a concept of mental disease and the underlying mechanisms that has altered all subsequent procedures. Many controversial points have arisen and many are still unsettled. While there has not yet developed an exact science in this field, much has been done that is serviceable in the field of psychotherapy.

Psychotherapy may be broadly defined as an effort to influence in the right direction the attitude of the patient—to influence his attitude toward himself, toward his mental and physical processes, and toward his environment. It is an effort to teach him to understand himself, his illness, and the cause or causes of his illness, whether this cause or these causes lie in his body, in his environment, or in the superficial or deeper layers of his mental life. The method or methods by which this is undertaken vary considerably. As expressed by Thom,[2] the nature of the therapy may be conditioned by (1) the personality make-up of the patient; (2) the nature of the symptoms; (3) conditions under which the symptoms are acquired; (4) the purpose they solve; (5) whether the precipitating causes continue to operate; and (6) the method in which the therapist has the most confidence.

PROCEDURE IN THE TREATMENT OF PSYCHONEUROSES

A method of procedure in the treatment of the psychoneuroses as advocated by Strecker and Ebaugh[3] may be stated as follows:

1. *Establishment of Rapport Between the Physician and Patient.* — The methods followed in

establishing that feeling of respect and confidence in the physician, which must prevail if the patient is to proceed successfully in his treatment, vary greatly. Shiny instruments and long, ambiguous words have played their respective parts. An effective method, however, and one that observes the dictates of sound medicine, is a careful program of investigation instituted at the first interview. A complete history should be a history of the patient as well as of his symptoms. A careful physical examination should follow, with recourse to those instruments of precision such as the x-ray and electrocardiograph which are specifically indicated, to complete your investigation and not to impress the patient. The doubt of the patient, who has been too exhaustively examined, is equaled only by the doubt of the skilled technician who knows the limitations of his instrument; and it bears no relationship to the confidence of the physician who blindly orders another x-ray, or basal metabolism, or blood chemistry, hoping thereby to convince the patient of the absence of a proper foundation for his symptoms. A mental examination should include not only the evaluation of his intellectual capacity, but also a consideration of his emotional responses.

2. *Aeration or Ventilation.*—This may be carried out by means of direct interviews, by means of discovering and probing for such material from outside sources, by hypnosis, or by any other method. The important thing is that the patient is given an opportunity to discharge and bring out in the open all of those experiences which have been causing him serious concern, either consciously or unconsciously.

3. *Desensitization.* — This is the procedure wherein the patient is required to face frankly the traumatic and unpleasant experiences of his past. It is brought about, in the first place, by causing the patient to discuss, at frequently repeated intervals, the material of conflict elicited. These interviews are repeated until the patient can review these experiences without excessive emotional concern. Normal emotional response is to be expected, however, and it is not desirable nor necessary to expect a complete loss of emotivity in connection with the events that should normally cause concern. It is the excessive concern that is pathologic and requires to be relieved.

The term "desensitization" is also applied to the procedure followed in relieving fear or other manifestations of symptoms in definite situations. The patient is required to face the situation repeatedly until he no longer manifests the symptoms in that situation, or until he is able to tolerate or ignore the symptoms if they do occur. It is necessary, of course, to encourage and reassure these patients repeatedly while this procedure is being carried out.

4. *Reëducation.*—This accompanies the foregoing procedures. It is essentially the development of clear insight on the part of the patient into the mechanism of the illness, the establishment of new habits of response (as in desensitization), and the formulation by him of an adequate industrial, social, recreational, and otherwise useful program of activity to insure future stabilization.

5. *Desensitization of the Family.*—In addition to the foregoing, it is often advisable to desensitize the patient's family to his illness, and to reëducate them into new habits of response toward the patient.

6. *Remedy of Physical Factors.*—All contributing physical factors are corrected as far as possible. Measures for their correction are instituted at the earliest possible interview, and are utilized as psychotherapeutic aids.

The procedures outlined, to be carried out intelligently, require that every individual case be formulated in terms of its causative factors in such a way that the factors that can be modified are emphasized, and become the center of attention. Factors which cannot be altered are recognized as such, and the patient is trained to tolerate them.

The development of child guidance has introduced many new procedures, valuable alike to the psychiatrist and to the pediatrician. It has emphasized beyond anything else the importance of case studies in personality and psychiatric problems. It has effectively liberalized the social point of view of psychiatry.

A matter of great importance in the consideration of psychotherapy, as it concerns the frankly psychotic patient, is that it begins with the first professional contact with him. Highly trained personnel are greatly handicapped, and the benefit of elaborate equipment is almost nullified, if the patient encounters only difficulty and disgrace in his efforts to secure such services. As long as a legal and disciplinary attitude prevails in the procedures through which a patient is admitted to a hospital for the treatment of a mental disorder, therapy directed toward that patient's recovery will be seriously handicapped. It is of the greatest importance that the work of revising the laws governing the admission of patients into the state hospitals be carried on as the first step in a program for adequate psychotherapy in those institutions.[4]

Stanford University School of Medicine.

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DISCUSSION

H. Douglas Eaton, M. D. (1136 West Sixth Street, Los Angeles). — The need for a scientific type of psychotherapy in this country, and especially in our own state of California, is evidenced by the number of cultists who surround us. Christian Science, Unity, New Thought—all represent narrow attempts to fill a definite need, and their existence is a challenge to the medical profession. As Doctor Johnson has pointed out, the percentage of functional disorders, a group peculiarly susceptible to psychotherapy and a group

we are all called upon to treat, represents, in a conservative estimate, 50 or 60 per cent of all our patients. In treating these cases, many of us either entirely ignore the value of psychotherapy or utilize it blindly and unintelligently.

Doctor Johnson is to be congratulated on his clear exposition of psychotherapeutic aims and methods. A careful study of Doctor Johnson's paper will be of value to us all, wherever our special interest in medicine may be, and I find myself even more thoroughly in accord with Doctor Johnson's views after a study of his paper than I was when I heard him read it.

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Clifford W. Mack, M. D. (Livermore Sanitarium, Livermore).—The treatment of mental and functional nervous diseases was for a long time in medical practice confined entirely to the somatic approach. Doctor Johnson has given us a very sane and clear-cut discussion of the treatment of these illnesses by psychotherapy. In this analysis he does not neglect the physical side, but at the same time he shows that the mental symptoms should be attacked by study of the psychic mechanism. We have long since passed the time when the mental and nervous patient is treated solely by correcting the physical abnormalities by surgery, or only on the basis of some reflex disturbance.

One of the most difficult tasks is to convince the family and friends that the essential features of the illness are in the realm of the patient's psychic or emotional life, and that they are not caused by some bodily disease. The patient even may grasp this idea much more readily than members of the family. I fully agree with Doctor Johnson as to the necessity of the reëducation of the family as well as the patient. I have often seen the work of many weeks destroyed in a short interview with the patient by some member of the family who wished to practice his or her own type of psychotherapy, or present some new theory about the illness.

There is only one point which I wish to add, and that is to call attention to the importance of suggestion as well as psycho-analysis. It may properly be argued that suggestion is only symptomatic treatment, but in no field of medicine can we neglect the value and usefulness of something that will alleviate or nullify troublesome symptoms. Doctor Johnson's exposition of the subject is of very valuable assistance to all of us engaged in treatment of nervous and mental patients.

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Thomas G. Inman, M. D. (2000 Van Ness Avenue, San Francisco).—This article by Doctor Johnson may be taken somewhat in the nature of a declaration of principles signalizing, as it does, his entrance into the field of neuropsychiatry in California. And these principles prove to be quite sound, when gauged by modern conceptions of mental disorders.

As he has intimated, rule-o'-thumb methods are insufficient in themselves, and no hard-and-fast rule can be laid down which will be applicable to each individual patient. Yet, method is necessary, and every physician doing this kind of work must have a definite plan which he uses in his search for the causes of the disorder at hand.

Doctor Johnson has outlined very closely the aims of such an investigation, as well as the direction which treatment must take. His broad views inspire confidence, and lead to the hope that his work here may bring about a more complete understanding of this, as yet, obscure subject.

The closing comments upon the method of commitment of the insane in California voices the opinion of everyone interested solely in the personal welfare of these unfortunate patients. The primitive methods now in force seriously interfere with the early institution of treatment, and undoubtedly do much to prolong the period of hospitalization.

COMPULSORY HEALTH INSURANCE*†

By Frederick L. Hoffman, LL.D.
Philadelphia, Pa.

XI

SOCIALIZED medicine is reviewed in the *Literary Digest* of December 29, 1934, in its annual review of progress made during the year in science and engineering. After an enumeration of outstanding discussions in the field of medicine, it is said:

"Socialized medicine," or the placing of physicians on government payrolls, and "health insurance," or provisions of medical treatment for the payment of small, regular, voluntary fees, were leading plans proposed. Both were bitterly opposed by officials of the American Medical Association, but health insurance was advocated by increasing numbers of physicians, dentists, nurses, and social agencies; by city, county, and state medical societies, and by the American Hospital Association, and the American College of Surgeons.

In this statement, however, the compulsory feature of the system is not emphasized, and that goes to the root of a very disturbing situation. It is seriously to be questioned whether the medical profession at large is more than vaguely conscious of what is actually implied in the various proposals. And unless it is aroused out of its apathy it may realize when it is too late that its professional independence has been sacrificed for a mediocre amount of economic security.

MAJOR PROPONENTS OF COMPULSORY HEALTH INSURANCE

The propaganda for compulsory health insurance is largely in the hands of and within the control of nonmedical men supported, in part if not wholly, by some of the great foundations more or less international in character and purpose. The outpourings of briefs and reports reveal no thorough grasp of the proper medical considerations, but rather the academic viewpoint of the green table and easy chair philosophy. It is supported by pleas for the poor or underpaid workers whose medical needs are said to be badly neglected. It insists that the medical care of the lower-wage group should be raised to the very best that can be provided, although the richest nation of the earth could not meet the expenses which would call into being a huge administrative apparatus largely of a nonmedical nature. The British health insurance committee makes the bold assertion that this is an "Act to provide against loss of health," but no agency has come into existence in the twenty-one years of its life to provide in an effective manner against the onset of disease. It may be safely asserted that the health of the British

* One of a series of articles on compulsory sickness insurance written for California and Western Medicine by the well-known consulting statistician, Frederick L. Hoffman, LL.D. Articles in this series were printed in issues as follows: I, in April, 1934, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33; V, in August, page 114; VI, in September, page 177; VII, in October, page 262; VIII, in November, page 323; IX, in December, page 398; X, in February, 1935, page 108.

† Note—As stated in the editorial masthead, "Authors are responsible for all statements, conclusions and methods of presenting their subjects" in California and Western Medicine. See also editorial comment in this issue, page 190.

worker, or of the insured members of his family, is not much better today than it was before the Insurance Act came into being.

HEALTH INSURANCE VERSUS SICKNESS INSURANCE

For the insurance of health is a totally different matter from insurance against loss of health through sickness, demanding chiefly medical treatment or more or less successful curative measures. The Act provides compensation for loss of employment due to ill health, but does not go to the root of a radical change in housing and living habits, which are possible factors responsible for widespread physical impairments. Through other agencies, it is true, every government the world over aims at an improvement of environment, as well as of the living habits, of its wage-earners to promote health and long life; but these agencies are not intelligently correlated to proper health insurance, being rather in the nature of relief agencies concerned with the economic consequences of sickness.

ROOT OF MOST ILLNESS

A careful review of the annual reports of health officers of England and Wales, Scotland and Northern Ireland is not suggestive of the fact that national health insurance forms an integral part of the public health organization. The root of most of the illness lies in the effect of housing and nutritional, as well as industrial, conditions inimical to good health and long life. In other words, the prevention of disease is still in a very backward condition, while vast amounts of money are being spent on the cure of disease, mostly in the nature of minor ailments. This is clearly shown in the last report of the chief medical officer of the British Ministry of Health (1933), who gives a table showing the proportion of cases of certain diseases to the total cases treated by insurance practitioners in 1933, which is supposed to be a representative sample of the entire experience. The table shows that out of 125,646 cases treated, 29,698, or 23 per cent, were for bronchitis, tonsillitis, nasal catarrh, colds, etc. The next most important item was influenza, represented by 14,905 cases, or 11.9 per cent. The third factor of outstanding importance were diseases of the digestive system, with 13,915 cases, or 11.1 per cent. These three groups, therefore, represented 46.6 per cent of the total.

Of the remainder, lumbago and rheumatism came first, with 11,329 cases, or 9 per cent of the whole; followed by injuries and accidents with 10,809 cases, or 8.6 per cent, and abscess, boils, and other septic conditions with 8,803 cases, or 7 per cent. Thus, these six groups combined, mostly of a minor nature and involving heavy expenditure on the part of the insured, represented 71.2 per cent of the total cases treated.

With regard to chronic diseases, tuberculosis, all forms, was represented by 905 cases, or 7 per cent of the total; organic heart disease, with 1,589 cases, or 1.3 per cent; anemia with 1,578 cases, or 1.3 per cent; diseases of the nervous system, with 7,046 cases, or 5.6 per cent; and skin diseases, with 6,112 cases, or 4.9 per cent.

Of the more serious and often prolonged respiratory diseases, pneumonia accounted for 1,699 cases, or 1.4 per cent of the total. Diseases of the genito-urinary system numbered 3,854 cases, or 3.1 per cent; while malignant disease or cancer numbered 221, or 0.2 per cent.

LIMITATIONS OF NATIONAL HEALTH INSURANCE

Hence it is clear that most of the money in national health insurance is spent upon trivial ailments, many of which are merely alleged conditions to secure relief by unemployment. Hospital care and surgical treatment are not provided for by national health insurance, but if provided would easily double the cost of the system.

Comparing the death rates for some of the more serious afflictions, including chronic diseases, the record for the last ten years is as follows: Erysipelas increased from 1.8 per 100,000 to 2.5; encephalitis lethargica from 0.9 to 2.1; cerebrospinal fever from 0.9 to 3.0; cancer from 122.9 to 151; nonmalignant tumors from 2.7 to 3.9; chronic rheumatism and osteo-arthritis from 5.9 to 7.9; diabetes from 11.9 to 15.2; diseases of the thyroid and parathyroid glands from 2.7 to 4.5; cerebral thrombosis from 6.2 to 11.6; paralysis agitans from 1.9 to 3.5; disseminated sclerosis from 1.9 to 2.2; aortic valve disease from 7.8 to 8.4; mitral valve disease from 24.6 to 25.2; myocardial degeneration from 40.4 to 117.4; diseases of the coronary arteries and angina pectoris from 3.8 to 19.1; disordered action of heart from 1.6 to 6.5; aneurysm from 2.7 to 3.2; lobar pneumonia from 24.1 to 24.9; ulcer of the stomach or duodenum from 6.8 to 9.9; appendicitis from 7.2 to 7.5; hernia and intestinal obstruction from 11.1 to 12; biliary calculi from 2.6 to 3; diseases of the gall-bladder and ducts from 1.7 to 2.8; diseases of the pancreas from 0.6 to 1.3; nephritis, all forms, from 33.2 to 40.6; other diseases of the kidney and annexa from 1.6 to 2.6; calculi of the urinary passages from 0.8 to 1.1; diseases of the prostate from 11.6 to 22.4; diseases of the skin and cellular tissue from 4.5 to 4.9; diseases of the bones from 2 to 2.4.

On the other hand, of course, many diseases have diminished in incidence, but I have for the present considered only those which I am claiming are not receiving adequate and proper attention under national health insurance. The foregoing figures have all been abstracted from the annual report of the Registrar General for 1932, covering the period of 1922-1932.

SOME BRITISH OPINIONS ON THE LIMITATIONS OF HEALTH INSURANCE

The present limitations of national insurance in Great Britain are recognized by every authority on the subject, and countless reports voice the opinion of its inadequacy in unmistakable terms. For example, at a recent meeting of the Nottingham Insurance Committee, the chairman, in his report, observes:

"The work in insurance committees is to deal with the maintenance of a healthy life of insured persons, and to provide medical attendance and other measures for such of them as fall out of health, and the extension of the medical service should, I think, be one of the first considerations. There is no need for me to dwell on the present inadequacy of the medical service, well though the majority of panel practitioners play their part. . . . I am of the opinion that it is essential in the interests of insured persons that the supplementary services, so much discussed in the past, are necessary today in order to secure a complete and adequate medical service for the insured community, and in addition thereto a system of medical treatment and attendance by panel practitioners to the dependents of insured persons, administered by and through insurance committees."

Furthermore, the chairman observes:

"I do feel, however, that eventually the National Insurance Act will of necessity have to be amended on the lines of the new Unemployment Insurance Act so as to bring boys and girls on leaving school within its scope, as the inconsistency in our two great social schemes cannot, I think, be reconciled for long." (*National Insurance Gazette,* November 15, 1934.)

In a report concerning the Medical Service Subcommittee of the London Insurance Committee, October 25, 1934, mention is made of the procedure followed in the case of a panel doctor who had failed to diagnose correctly cancer of the lung. The subcommittee said that, as a result of their consideration of the case, they found that the insured person had received proper attention, although he died from a cause not diagnosed. The subcommittee recommended concurrence with local medical committees' view that the following services were outside the scope of terms of service, and practitioners concerned might charge patients privately therefor: "(1) Enucleation operation for removal of tonsils by dissection; (2) ultra-violet rays for asthenia; (3) local treatment with Tungsten arc lamp for ringworm on neck; (4) estimation of refraction—subjective and by retinoscopy for presbyopia; (5) retinoscopy and prescribed spectacles; (6) retinoscopy and ophthalmoscopy; (7) ultra-violet rays for postherpatic neuralgia; (8) retinoscopy and prescribing glasses; (9) dilation and curettage for chronic endometritis; enlarged uterus, chronic backache, discharge and menorrhagia."

I quote also from a report of Dr. L. Llewellyn-Jones, one of the foremost authorities on national health insurance in England, who presided at the meeting of the Flintshire committees, November 8, 1934, and is stated to have said that

"He himself was sorry to see the tendency nowadays in the direction of bureaucratic policy, which he thought was a huge mistake in the administration of national health. The experience gained in the last twenty-one years of the benefits of national health insurance had shown that there was a great deal to be done before they could sit down and say they were well satisfied. The scope of medical benefit at present was a comparatively narrow one. As soon as an insured person required treatment which necessitated a consultant or the services of an expert surgeon the resources of insurance committees came to an end, and they were not in a position to arrange for that further treatment. There was nobody today who did not feel there was a gap which ought soon to be filled if they thought that the scheme was what they thought it was going to be twenty-two years ago. There was another line of advance which he would like to see. And that was a closer connection and correlation between the insurance services and the public health services of the local authorities. There was a section of the 1911 Act which seemed to contemplate that, but it had never been put into operation. In 1924, when the Government brought in a Consolidating Act, that section was dropped. There ought to be much closer coöperation between the two bodies than existed at present. He would like to see an attempt made to bridge over the gap between the time a child left school and the time it entered the national health services. They, as insurance committees, could do a great deal in the way of impressing public opinion with the reasonableness of what they were claiming, and as regards paying more attention to matters of public health whether on the clinical or on the preventive side."

The foregoing extracts will clearly illustrate the limitations of health insurance inherent in the system, and the inadequacy of the contributions to provide for all the emergencies that may arise chiefly, however, in connection with prolonged cases of chronic illness which are not properly provided for under the present system.

AN ILLUMINATING SIDELIGHT ON PANEL PRACTICE

An illuminating sidelight on panel practice is contained in an article in the London *Lancet* of September 29, 1934, which bears the suggestive heading "Placebo Prescribing." Placebo, according to the medical dictionary, is "An indifferent substance, in the form of a medicine, given for the moral or suggestive effect." In other words, placebo is a pretense and a fraud. In the article referred to, the question is raised as to whether patients as a rule expect a prescription or a bottle of medicine when they consult a doctor, it being stated that the chemists' accounts for insured persons increased from a total of about $9,046,000 in 1932 to a total of about $9,632,000 in 1933. It is then said:

"All doctors are familiar with the patient's statement that the very first dose did him good, and it would be a foolish man who refused to repeat that mixture. There is the story of the old lady who could not do without her cough mixture, and on one occasion when she sent up for it and her doctor was out his wife put an ounce of Camp coffee in the bottle, filled it up with water, and told the messenger that the mixture has been changed. Most practitioners who dispense keep a mixture labelled "ADT": A for any, T for thing, D for what you like—to be used for people who are thought not to require medicine at all, but who would consider themselves neglected if they did not get something."

UNNECESSARY MEDICINE AND ITS COST

Attention is next drawn to the fact that Sir George Newman, in his annual report, raised the question of unnecessary medicine and its cost. In other words, a vast amount of prescribing serves no useful purpose, but is in the nature of a fraud upon the insured who are given a medical concoction as a matter of pretense and downright imposition. But the vast amount of trivial ailments in the doctor's practice could not result in any other procedure. As I said before, the patient is chiefly interested in a certificate for incapacity for work entitling him to a cash benefit, and as long as this is true the condition referred to is not

likely to be improved upon. The article observes that the general cost of prescribing has gone up and continues to go up. Sir George Newman states that is due to the modern tendency to prescribe expensive drugs, such as insulin and liver extract, and that inasmuch as these drugs are necessary, it becomes more than ever important that money which should be available for their cost is not frittered away in placebos. But the doctor in question has no alternative that may involve the risk of losing his clients who would transfer to a more complacent medical attendant. As said in the *Lancet* article:

"The determining factor in the doctor's view is the fear of offending his patient, thereby risking the loss not only of that patient, but possibly his family and relatives. But whilst cantankerous patients leave Dr. A., they also leave Dr. B. and Dr. C., so that what Dr. A loses in one family he gains in another."

In a further article in the *Lancet* on the same subject, it is said, referring to Sir George Newman's report:

"You say 'the public appreciates what it has to pay for.' As it is, panel patients have a suspicion that the panel doctor's medicines are not so good or 'so strong' as those prescribed by private doctors or by the same doctors for their private patients. A common remark is: 'I told him I didn't want any panel stuff and he gave me a bottle of really good medicine. You see they won't let them give really good medicine on the panel except when you are very ill indeed.' Whether we are wise to attempt to take away the prop that a bottle of medicine provides when we have so little else curative in our armamentarium is again another matter. It seems likely that the quack dispenser would have scope for a flourishing trade if doctors really gave medicine only when it is required. Before we manage to do without a bottle of medicine we shall probably have to invent some other symbol or idol."

NUMBER OF PERSONS INSURED IN GREAT BRITAIN

Several references have been made in this and previous papers to the increasing sphere of national health insurance in Great Britain by the inclusion of new categories of members, particularly the young between sixteen and eighteen years of age. According to a recent statement by Sir Hilton Young of the Ministry of Health, the numbers of persons in Great Britain who, on December 31, 1933, were insured for health and pension purposes, respectively, were approximately 18,481,000 and 18,793,000. The number of insured persons under twenty years of age on December 31, 1931, was approximately 2,500,000. Thus, to the extent that the number of insured increases, the sphere of the private practitioner is curtailed. In Germany the number of members in compulsory health insurance sick funds increased from 17,539,000 in January, 1933, to 20,163,000 in June, 1934. The experience elsewhere has been similar.

The application of the foregoing facts and information, concerning the experience of compulsory health insurance abroad, to American conditions is obvious. Unless we are ready to merge a large proportion of our doctors in a federal health insurance service, we had better consider the possible effects on the general medical practice. Of course, the agitation for compulsory health insurance rests, to a large extent, upon the free treatment of the poor for which compensation should be made by the State.

HOW CAN INDUSTRY ASSUME THE BURDEN OF NATIONAL HEALTH INSURANCE

The demand that industry shoulder a large proportion of the cost of compulsory health insurance is a preposterous imposition. Industry as it is has a hard enough time to avoid bankruptcy in view of the immense hardships of interstate competition. Its position would be infinitely worse with compulsory health insurance demanding that 50 per cent of the contributions be paid for by the employer. Nothing would suit European nations better than for us to assume such a colossal burden, to equalize still further the economic differences between this and other countries. Efficient medical practice is difficult enough as it is, and should not be burdened with an immense variety of rules and regulations and supervision and control on the part of state and federal authorities which would hinder its progress and curtail opportunities now open to all physicians engaged in private practice. Once such a bondage has become an established fact, it is extremely difficult for any country to do away with it.

PROPOSED BILL OF THE AMERICAN ASSOCIATION FOR SOCIAL SECURITY (EPSTEIN BILL)

Regardless of our precarious financial situation, social reformers are pressing their plans for socialized insurance with increasing vigor. An organization known as the American Association for Social Security, according to the New York *Times,* has made public its Social Security Bill † which, it is stated, will be introduced as a model measure in forty-three state legislatures now convening, and the provisions will be made the basis of a federal subsidy bill to be introduced into Congress in the near future. It is said, in the article referred to, that "the two steps combined are designed to provide a health insurance system under which the great proportion of those earning less than $3,000 a year would receive essential medical services and part compensation for loss of income by illness."

The object of the federal bill is "the establishment of a system of health insurance which will provide protection of the population which is unable to budget individually for adequate health services or to bear the loss of income by illness. . . . Its basic aim is to equitably distribute the burden that illness involves. There is no attempt in this bill to reorganize the medical profession as such in any manner whatsoever." All this is mere meaningless verbiage, for the moment such a bill is enacted the medical profession will be drawn into it on a large scale, and will be divided into those who are on the Panel and those who are not. Compulsion for the payment of the contributions will be a most essential feature, and a heavy burden both upon the employers and the employees. In view of the reckless spending of

† For other comment concerning this bill, see Journal of the American Medical Association, February 2, 1935, p. 400.

federal money, the enactment of radical legislation of all sorts is by no means improbable, and such a measure may become a law unless the medical profession uses its utmost influence to protect its interests against adverse legislation.

BRITAIN'S FIGURES ON THE COSTS OF ITS HEALTH INSURANCE

What, in the long run, such a system may amount to in dollars and cents is best illustrated by the British experience with a record of nearly a quarter-century available. Since 1921 the total receipts from all sources, contributions, parliamentary grants and interest, have amounted to $3,187,781,000. Of this, the amount paid by direct parliamentary grants is represented by the tidy sum of $665,602,000. Of the total expenditure, $420,122,000 represents the cost of administration, compared with $140,641,000 for maternity benefits and $755,000,000 for medical benefits. This represents the cost for England and Wales only, with an approximate population of about forty million.

At the present time the annual receipts from contributions, parliamentary grants, interest, etc., amount to about £32,000,000, or not quite $150,000,000. That applied to the American population, with due regard to the higher standards of living and higher cost of compensation, would bring the annual cost of a system of socialized insurance to possibly a billion dollars, considering that many more benefits would be expected in this country than abroad.

COMPARISON OF GENERAL REVENUES OF CALIFORNIA AND MASSACHUSETTS

Since the States would have to bear a large proportion of the expense, let us consider the facts for the State of California compared with the State of Massachusetts, derived from the latest figures available from the Census Office.‡ For 1932 the per capita revenue of California was $106.85, while for Massachusetts, 1931, the corresponding figure was $89.51. The per capita expenditures were $113.78 for California and $96.31 for Massachusetts. The per capita gross debt, less sinking-fund assets, was $186.15 for California and $101.77 for Massachusetts. The per capita gross debt, less sinking-fund assets, has increased in California from $55.01 in 1912 to $142.81 in 1922 and $186.15 in 1932, and in Massachusetts from $75.28 in 1912 to $82.30 in 1922 and $101.77 in 1931.

RECENT HEALTH AND SANITATION EXPENDITURES IN CALIFORNIA AND MASSACHUSETTS

In an estimated population of about six million for California, the amount spent on health and sanitation in 1932 was $15,369,000. In Massachusetts, with an estimated population of about 4,500,000, the amount spent on health and sanitation in 1931 was $22,096,000. What is to be the future of State finances under such alarming conditions? In its last analysis, the burden of taxation falls most heavily upon the productive industries and the wage-earner's income. With the higher cost of living, which is inevitably in prospect, and with a substantial reduction in wages on account of health insurance or social insurance payments, the wage-earner may well pause to give approval to this fantastic scheme of reform which has little to commend it.

‡ Including the State and all local administrative areas.

MUTUAL HEALTH SERVICE OF WAYNE COUNTY, MICHIGAN

There is a way out of the difficulty which demands attention. In Detroit, Wayne County, Michigan, the county medical society has inaugurated a voluntary plan of medical service, with every assurance of success. What is possible in Detroit is possible in every other community in the United States, and the facts of the situation should be carefully studied by every local medical society.

In brief, the Wayne County Medical Society provides for a coördinating center, with a social service set-up, for those cases which require assistance in obtaining and paying for complete medical service, including hospitalization and medical, dental, nursing, and pharmaceutical service. This is more than the European plans provide at the present time, or are ever likely to provide. All the members of the society become the active staff caring for patients, and all forms of medical care, including consultation, x-ray, and laboratory procedures, are to be performed in the office or laboratory of the physician or at the hospital where he takes the patient. The plan includes hospitalization, all the major hospitals of Detroit, except one, coöperating.

Industrial concerns are coöperating by making the service known to their employees, while factories and shops also are coöperating by giving information and in the collection of accounts. The plan has been welcomed by every employer approached.

If the patient has no personal physician, he may choose one, and an identification card is given him to be presented to the doctor of his choice. If several physicians and a hospital coöperate in the care of a case, the bills or fees are combined into one bill, the physicians and hospital, not the Bureau, setting the fee. The payments when received are then distributed to each coöperating physician, hospital, dentist, or nurse. By this method the recognized patient-physician relationship is preserved. It is explained that this plan does not affect compensation cases. The patient has free choice of hospitals, specialists, and laboratories exactly as in private practice.

It is furthermore said, "The most important feature of this plan is that it places complete medical and hospital services within the reach of every worthy patient, and provides an easy payment for the settlement of medical bills."

The following facts are of particular importance. Wayne County has about 7,000 medical units, doctors, dentists, nurses, hospitals, and pharmacists, and approximately 1,100 industrial concerns employing more than one hundred workmen each. The coöperation of all these is neces-

sary if the plan is to be successful. The Detroit plan is as yet in its initial stage, and "the work of contacting employers has been sandwiched in between many other duties so that, to date, only thirteen industrial concerns have been approached. The total employment at the plants contacted is approximately 65,000 men. In each case the industrialist stated he would gladly tell his workers; he would also verify employment, wages, etc., in the investigation of the patient. In every case the manufacturer is willing to assist us in making collections. This is not surprising, because the plan offers many distinct advantages to the employer, such as (1) certainty that the employee will be well cared for; (2) relief from a portion of the necessity for employee loans; (3) greater efficiency through better health of employees; (4) one centralized bureau with which to coöperate; and (5) no dues, fees or payments of any kind before actual service has been received."

HOW THE WAYNE COUNTY PLAN HAS WORKED OUT IN PRACTICE

The Bureau began to function in February, 1934, and up to August 18, 1934, had handled 1,085 individual cases. According to *The Medical News* of Detroit for October, 1934, "the number of employees involved in the industries already actively coöperating with the plan is 229,980." In brief, the Detroit plan provides complete medical and hospital service within the reach of every worthy patient by means of an easy-payment plan for the settlement of medical service bills. Physicians and hospitals, not the Bureau, set the fee. Thus, the self-respect of the patient is preserved regardless of what the situation may be. Nothing more admirable has been evolved in all the numerous plans for socialized medicine on a compulsory or voluntary basis. As observed in a report on the bill in *The Journal of the American Medical Association* for September 8, 1934: "The plan should increase the health and happiness of Detroit and Wayne County citizens, as it provides a method whereby people can procure needed medical services. It should remove a large proportion of the financial reasons for delaying medical service. The consolidation of medical and hospital bills, with the arrangement of definite terms at the time the service is rendered, should result, with the coöperation of the employer and all concerned, in an increased ratio of collections."

And finally: "Physicians send their bills computed at their usual fees for these patients to Bureau headquarters, giving certain details of their charges. The physician does not make collection of these charges—the central bureau makes arrangements for collections and has the coöperation of the employer. To defray the cost of operating the Bureau, 10 per cent of sums actually collected is retained by the Bureau."

As regards those unable to pay for medical services at the time such service is rendered, it is said that in such cases the patients are always returned to their family physician with a plan of deferred payments, and that "the majority of these patients sought charity because they did not have sufficient cash in reserve to meet the full fees incident to a medical emergency. Their prime need was credit, not free medical care."

ADVANTAGES OF THE WAYNE COUNTY PLAN

Here, then, is a plan worthy of the most careful consideration on the part of those who sincerely believe that some form of medical reorganization is necessary to provide for the needs of poorly paid workers unable to meet their medical bills. The Detroit system eliminates entirely the need of compulsion and state interference, and avoids the extremely costly advisory bodies which come into existence in a system of compulsory health insurance. It preserves the independence and integrity of the medical profession and avoids class distinction both on the part of the beneficiaries of the system and the doctors. It eliminates an enormous amount of political discussion incident to compulsory administration, and leaves the doctor time for the scientific study of medicine. It should go far to improve the general health situation and to lower the death rate from preventive or curable diseases.

DEATH RATE IN BRITAIN AND THE UNITED STATES

With reference to the death rate, it may be pointed out that the rate for England and Wales in 1933 was 12.3 per one thousand, compared or contrasted with a rate of 10.7 for the United States during the same year. In 1912, when the British system was established, the death rate for England and Wales was 13.4 per one thousand, while that for the United States registration area for the same year was 13.9. In tabular form the comparative results are as follows:

COMPARATIVE DEATH RATES PER ONE THOUSAND, 1912 AND 1933

	England and Wales	U. S. Registration Area
1912	13.4	13.9
1933	12.3	10.7

Hence it is shown that while there was a decrease of 1.1 per one thousand in the death rate for England and Wales, the corresponding decrease in this country was 3.2. The first was achieved with health insurance and the second without it. The boasted benefits to the British population are largely a matter of conjecture, for in its last analysis the death rate is the court of last appeal in a discussion of this kind. The questions involved may be presented to advantage in a somewhat more convincing method of details.

Considering twenty-eight leading causes of death in the United States and England and Wales for the year 1933, it appears that eighteen causes show a lower death rate in this country, while ten show a higher rate. The combined mortality from those diseases showing a lower rate in this country was 747.5 for 100,000 for England and Wales, and 507.4 for this country; while for the ten causes with a higher rate in this country the combined rate was 211.9 per 100,000 for England and Wales, and 298.6 in this country. The diseases showing a lower rate for this country are given in Table 1, with the rates per 100,000 population.

TABLE 1.—*Diseases Less Common in the United States*
(Rate per 100,000)

	U. S. Registration Area	England and Wales
Influenza	26.4	56.7
Erysipelas	1.6	3.0
Tuberculosis (all forms)	59.5	82.4
Cancer and other malignant tumors	102.2	152.6
Acute rheumatic fever	2.0	3.2
Chronic rheumatism, osteo-arthritis	1.3	8.0
Diseases of the thyroid and parathyroid glands	3.3	4.6
Anemia	3.4	6.7
Diseases of the heart and circulatory system	249.8	330.4
Chronic bronchitis	1.5	18.4
Bronchopneumonia	29.3	40.8
Asthma	1.5	4.4
Pleurisy	2.1	2.3
Diseases of the buccal cavity, etc	4.5	4.9
Ulcer of the stomach and duodenum	6.0	10.2
Hernia, intestinal obstruction	10.0	11.8
Diseases of the skin and cellular tissue	1.7	4.9
Diseases of the bones and organs of locomotion	1.3	2.2

The diseases showing a higher rate in this country are given in Table 2.

TABLE 2.—*Diseases More Common in the United States*
(Rate per 100,000)

	U. S. Registration Area	England and Wales
Typhoid fever	3.5	0.5
Syphilis	8.8	3.3
Diabetes	21.3	15.6
Leukemia and pseudoleukemia	3.6	3.2
Alcoholism	2.6	0.2
Diseases of the nervous system	104.2	96.8
Lobar pneumonia	36.4	24.4
Appendicitis	14.1	7.6
Cirrhosis of the liver	7.4	3.1
Diseases of the genito-urinary system	96.7	57.2

The contrast in local disease frequency is highly instructive. Obviously the diseases which should benefit most under a health insurance system are higher than they are in this country, with the important exception of syphilis, diabetes, lobar pneumonia, appendicitis, cirrhosis of the liver, and diseases of the genito-urinary system. Syphilis and genito-urinary diseases, chiefly chronic nephritis, are affected by race, being much more common among the negro population. If it were not for the negro element, our general and specific death rates would be decidedly more favorable in contrast with the returns for England and Wales. Highly significant are the high rates for rheumatic fever and chronic rheumatism in that these two diseases receive major attention under health insurance. Hence the conclusion that our health system without health insurance is decidedly more favorable than that of England and Wales, and that indications for a further decrease in specific death rates are more pronounced in this country than in England.

In conclusion, I quote an interesting paragraph from a treatise on German medicine by the Hoeber Press, recently published. It is one of a series of volumes on the history of medicine and written by one who evidently speaks with authority on the questions under consideration. Regarding health insurance, he remarks: "The financial status of the medical profession became much weakened in 1883 by the introduction of the compulsory public sickness insurance (Krankenkasse). The physician's salary for the immense amount of work required under this system is most inadequate; the insurance covers a large part of the population: workingmen, clerks and their families, and so on. At first the insured persons did not have the privilege of choosing their physicians, but as a result of the efforts exerted by the 'Verbände der Aerzte Deutschlands,' this has been changed, and now the patients do have the privilege of selecting their physicians." (*Journal of the American Medical Association,* October 27, 1934, page 1330.)

IN CONCLUSION

With this statement I leave the subject which I have tried to present impartially in the light of such evidence available to me, both from German and British sources. To my mind, there can be no other conclusion than that the adoption of compulsory health insurance is not to the interest of the American medical profession, while it is equally opposed to the best interests of the public. I have given much of my time during the last thirty years to a patient study of the facts, and my earlier convictions as regards the inexpediency of compulsory health insurance remain unchanged. I trust that what I have written will be of benefit to the American medical profession and arouse organized opposition to any and every effort to force such an uncalled for system upon the American public, who, in its last analysis, have to bear the burdens of increased taxation and decreased economic efficiency in international trade competition.

THE LURE OF MEDICAL HISTORY*

THE INFLUENCE OF CLAUDE BERNARD ON MEDICINE IN THE UNITED STATES AND ENGLAND†

By J. M. D. OLMSTEAD, Ph.D.
Berkeley

II‡

BERNARD'S INFLUENCE ON THE TEACHING OF PHYSIOLOGY IN AMERICAN MEDICAL SCHOOLS

Many of the young American physicians who listened to Bernard's lectures afterwards became professors in medical schools in the United States, but hardly one carried on research along physiological lines. Dr. Henry H. Donaldson of the Wistar Institute of Anatomy gives us a picture of conditions in the 1880's which is particularly interesting because he had his physiology under Dalton: "In the eighties the teaching of medicine,

* A Twenty-Five Years ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department of CALIFORNIA AND WESTERN MEDICINE and its page number will be found on the front cover index.

† From the Division of Physiology, University of California Medical School, Berkeley.

‡ Part I of this article was printed in February issue, CALIFORNIA AND WESTERN MEDICINE, page 111.

with which physiology was mainly associated, was poorly developed. I entered the College of Physicians and Surgeons in New York in 1880. It was then a proprietary school. You paid your fee and were enrolled. You could get your degree in two years by attending endless lectures and taking quizzes with a preceptor. There was a dissecting room, but no laboratories. Dalton held the chair of physiology. He was lucid in his presentation, largely based on French work, for he had been trained in Paris. An exposed heart is the only demonstration I recall." It would appear that even if Dalton did at first attempt to illustrate his lectures with experiments "on living or recently killed animals," this ideal was not being put into practice in the later years of his career as a teacher.

The truth is that for years any one with an M. D. degree was considered qualified to teach any subject in the medical curriculum. An excellent example is shown in the case of Stanford Emerson Chaillé (1830-1911). Descended from a Huguenot refugee and born in Mississippi, he took his A. B. at Harvard in 1851, and his M. D. at the University of Louisiana in 1853. After another year at Harvard, getting his M. A., he embarked on a three-year European tour. He attended Bernard's lectures while in Paris. Upon his return to Louisiana he was for nine years a demonstrator in anatomy, serving, meanwhile, as surgeon in the Confederate Army during the Civil War; for a year he was lecturer in obstetrics, then became professor of physiology and pathological anatomy; for a short time he switched to the professorship of obstetrics, but later returned to the professorship of physiology and pathological anatomy.

It was not until very late in the nineteenth century that American medical schools became centers for investigation. In fact, the American Physiological Society, whose meetings were designed for the very purpose of discussing original investigation, was not formed until 1887. This society was started at the suggestion of Weir Mitchell and he was elected its first president. One is strongly reminded of Bernard's relations to the Société de Biologie of Paris, which he was instrumental in founding in 1848, and of which he later became perpetual president. Among the most active members of the American society was Henry Pickering Bowditch (1840-1911), professor of physiology at Harvard. Bowditch's father had been one of Louis' most enthusiastic followers and had spent the years of 1832-1834 under Louis' guidance at the hospital of La Pitié. Although it is stated that the son "came into relations with Claude Bernard in Paris," he actually did his work abroad in Ludwig's laboratory in Leipsic.

One must admit that almost without exception these young American physicians who continued their medical studies in Paris were really interested in the more practical aspects of medicine. In England this was not the case. There were, of course, many English physicians who listened to Bernard and returned home to practice. They, too, could follow Bernard's more recent discoveries in their own medical journals, and could even read notes on complete series of lectures, such as those of Dr. Benjamin Ball published in the *London Medical Times and Gazette,* 1860-1861; which, by the way, were translated back into French for use as part of the text of the volume on Operative Physiology published after Bernard's death. But, in contrast to the state of affairs in the United States, the teaching of physiology in the great educational centers of England where the science was being advanced bears the stamp of Bernard's direct influence.

THE TEACHING OF PHYSIOLOGY IN BRITAIN'S MEDICAL SCHOOLS

When William Sharpey (1802-1880) came from Edinburgh to occupy the newly instituted chair of General Anatomy and Physiology at University College, London, in 1836, he had had training chiefly in microscopic anatomy. Sir Edward Sharpey-Schafer makes the following statement regarding Sharpey's teaching: "It is true that his lectures were largely anatomical, that he carried out no physiological researches, that he performed no experiments on muscle and nerve other than those which had been performed by Galvani half a century earlier, that he never possessed a kymograph (the working of which he would illustrate to his class by revolving on the lecture table what Michael Foster called his 'dear old hat'), but he had a remarkable grasp of the problems of physiology, and a singular power of imparting his conclusions to his audience."

Sharpey, wishing to do more to encourage the science of physiology in England, induced a young physician, George Harley (1829-1896), to start in 1855 a class in Practical Physiology at University College. Why should he have chosen this particular young man? Like Sharpey, Harley had taken his M. D. at Edinburgh (1850), but during two years spent in Paris he had received special training in physiology under Magendie and Bernard. It was to this young man that Bernard referred when he spoke of "M. Harlay *(sic),* who at one time took my course." Under Bernard's direction Harley worked on the effect of injecting irritating substances into the portal vein. This was the period of intensive work in Bernard's laboratory on the glycogenic function of the liver. The impetus which Harley received is seen in his two treatises on the liver, the first written in 1853, the second twenty years later.

About the time that Harley was introducing Bernard to University College, London, Frederick William Pavy (1829-1911), was doing the same at Guy's Hospital. Pavy, after taking his M. B. with honors at the University of London in 1852, followed the custom and left for further study in Paris. There were so many English medical students in Paris in the fifties that they had organized the English Medical Society of Paris, which met weekly in rooms near the Luxembourg to read papers and report on interesting cases.

Both Harley and Pavy were officers in this society. Pavy's experiments under Bernard's direction on the mechanism of the destruction of sugar in the organism were characterized by the master in one of his lectures at the Collège de France as "très intéressantes." Pavy was so profoundly influenced by Bernard that he, too, devoted his life to the subject so intensively worked on by the master, viz., diabetes, and was even said to imitate him in the manner of his lectures. Two of his books are "Researches on the Nature and Treatment of Diabetes" (1862) and "The Physiology of the Carbohydrates, Their Application as Food and Relation to Diabetes" (1894). Pavy's later experimental work seems to have been largely an attempt to improve on Bernard's method of sugar estimation. He disagreed with Bernard on the subject of glycogenesis, for he did not get the same results as Bernard had done in determining the relative amounts of sugar in the blood of the portal and hepatic veins. One of the few times Bernard attacked an adversary with sarcasm was when he refuted "the ideas held particularly by M. Pavy, an English physiologist, who began his experiments on animal sugar in my very laboratory at the Collège de France," that the appearance of sugar in the liver is a postmortem phenomenon. "M. Pavy's theory is a reflection of the old vitalistic doctrines and is at the same time obscure and inexact. . . . M. Pavy would thus be led to consider the diabetic patient as a walking corpse, a conception which is certainly bizarre!"

Harley did not long retain his lectureship in Practical Physiology at University College; he was soon followed by Michael Foster, a pupil of Sharpey, who had taken his M. D. at the University of London in 1859. Foster, although he, too, had followed the custom and spent a year in Paris, did not attend Bernard's courses; nevertheless, it is claimed that the greatest influences in Foster's life were Sharpey, Bernard, and Huxley. The greatness of his esteem for the French physiologist is expressed in the dedication of his well-known biography of Bernard: "To the physiologists of France, both to those who had the happiness to know Claude Bernard in the flesh, and to those who, like myself, never saw his face, this little sketch is dedicated in the hope that as he has been to me a father in our common science, so I may be allowed to look upon them as brethren."

When Foster left London to accept the chair of Physiology at Cambridge, a clever clinician, who, under the influence of Sharpey, had in 1866 carried out some physiological experiments on respiration at University College, followed him as lecturer in Practical Physiology, with the understanding that he would have the chair of Physiology on Sharpey's retirement. This clinician was Dr. John Scott Burdon-Sanderson. Here was another Edinburgh graduate in medicine (1851), who had joined the group in Paris immediately after taking his degree. His diary of this period gives us brief pictures of his life there, now attending lectures and laboratories with students whom he had known at home, Harley, Pavy, and others, now reading before the Paris Medical Society a paper "which was not understood." On March 1, 1852, there is the following entry in the diary: "Went with Marcet to Bernard's, who showed us much attention." This is followed the next day by "Went with Harley and Mason to Bernard, who introduced us to Magendie!" On March 13, 1851, occurs the entry, "Was with Bernard performing several experiments." Among other entries scattered along the diary are the following: "Performed operation for obtaining pancreatic juice on a rabbit; did not succeed in introducing the cannula"; "injected a pigeon"; "operated unsuccessfully on a dog for pancreatic juice"; "operated successfully on pancreatic duct," etc. A more elaborate notebook of this date in his handwriting gives a synopsis of Bernard's experimental lectures, and treats some subjects in much detail, notably, the rôle and nature of glycogen and the phenomena of diabetes. In fact, he "seems to have fallen under the magnetic spell cast by the intellectual personality of the great physiologist." His veneration for Bernard lasted throughout his life, and in later years he used to say, pointing to the bust which stood upon the shelf above his study table, that Bernard was the most inspiring teacher, the most profound scientific thinker and the most remarkable experimental physiologist that he had ever known." In 1883 Burdon-Sanderson left London to accept the chair of Physiology at Oxford.

Thus, at London, Cambridge, and Oxford, the tradition of Bernard's teaching was carried on, and carried on so effectively that at the beginning of this century preëminence in physiology passed from France to England.

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CLINICAL NOTES AND CASE REPORTS

LYMPHOPATHIA VENEREA

By Anthony B. Diepenbrock, M.D.
James J. McGinnis, M.D.
Rodney A. Yoell, M.D.
and
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TWO cases of local (San Francisco) origin of Lymphopathia venerea (Lymphogranuloma inguinale), conjugal, are herewith reported.

Case 1 (Husband).—A. P., an Italian male laborer, age thirty-two, consulted one of us (Diepenbrock) at his office on December 6, 1929, on account of a painful swelling in the left groin, producing difficulty in walking, chilly sensations, profuse perspiration, and fever. About ten days previously he observed a small painless papular lesion on the glans penis, which disappeared in a few days. Three or four days later pain and tenderness developed in the left groin, followed by a small, tender swelling, which grew larger, until finally he became disabled. He admitted coition during the middle part of November with an unknown person picked up on the streets. He also admitted subsequent coitus with his wife who, at the time, was about eight and one-

half months pregnant, and at this time was in the hospital after her accouchement.

Physical examination was generally negative, except for the left groin, which presented an exquisitely tender, firm, non-fluctuating, irregularly nodular mass occupying a large part of the inguinal region. This apparently represented a large number of confluent, enlarged lymph nodes, together with a great deal of inflammatory subcutaneous tissue involvement. The overlying skin was discolored with a purplish erythema, and was not movable over the mass, while the mass itself was fixed to the underlying tissues. At this time there was no remaining evidence of the penile sore, and there was no urethral discharge. However, a urethral smear was made and found negative for gonococci; a prostatic smear likewise showed no gonococci. The Wassermann was negative. The blood count showed nothing worth noting. The urine was normal.

The patient was sent to St. Mary's Hospital, where complete excision en masse of the contents of the left groin was made by Dr. Rodney A. Yoell, and the wound permitted to heal by third intention.

Subsequently the patient had an intermittent fever with daily fluctuations up to 102 degrees Fahrenheit for about eight days, followed by another week with lower daily fluctuations. At the end of twenty-two days, on December 28, 1929, he was sent home, although the wound had not as yet healed. On February 13, 1930, he reëntered the hospital; this time on account of swelling tenderness, redness, and pain in the right groin, and a recurrence of the swelling in the left groin. The previous operative wound had completely healed, but just below it was a mass about 2 centimeters in diameter, painful to the touch, not fluctuant, and firm. It had the appearance of a large lymph node. The overlying skin was normal. The right side gave the same appearance as the left side on the previous entry. At this time the temperature was normal. Two days later an en masse excision of both groins was done; the patient made an uneventful recovery and was discharged, with both operative wounds healed, on the 11th of March.

Pathological examination of the tissue removed showed that it consisted of enlarged lymph nodes in thick fat, with several cavities containing a thick, creamy, odorless purulent material. Microscopically, the lymph nodes were edematous, with small abscess cavities and much leukocytic infiltration. There was nothing in the specimen suggestive of tuberculosis. Smears from the purulent material showed no organisms of any kind. Cultures and tissue sections showed no bacteria.

* * *

Case 2 (Wife).—G. P., an Italian housewife, age twenty-five, wife of the first patient, on December 2, 1929, entered the hospital, where on the following day she gave birth to a full-term, normal, male child. On December 16, 1929, she was discharged, recovered from her accouchement but complaining of small, painful lumps in both groins. She was treated at home with hot fomentations, but the swellings became progressively greater and more painful. There were no chills or fever.

On February 11 she was forced to reënter the hospital. At that time examination revealed a group of enlarged, painful, tender, slightly fluctuating lymph nodes in both groins. Each mass occupied almost the entire inguinal region. The overlying skin was reddish violet in color on both sides, and fixed to the mass. The Wassermann was negative. Vaginal and cervical smears were negative for gonococci. The blood count was normal; the urine, negative. The general physical condition otherwise negative. On February 12 complete excision of both inguinal masses was done by Dr. Rodney A. Yoell. Subsequently she made an uneventful recovery, and was discharged with wounds healed on March 11, 1930.

Examination of the removed tissue revealed a condition identical with that of her husband. Smears and cultures were negative for microörganisms. Tissue sections revealed no bacteria. The lymph glands were enlarged, edematous, fibrotic in places; while in other places there was marked leukocytic infiltration with softening, and multiple minute and gross abscess formation. The neighboring fat was filled with lymphocytic infiltration. Outside the fibrous layer surrounding the abscesses were a few large, mononuclear giant cells with centralized nuclei.

On June 21, 1931, she was again admitted to the hospital on account of a marked hydrops articuli in both knee-joints. Other joints were normal. The Wassermann was again negative; the blood count, normal; the urine, normal; the general physical condition was good. Both groins were normal, except for operative scars. No enlarged glands were noted anywhere. The temperature was slightly elevated. Vaginal and cervical smears were negative for gonococcus and Ducrey's bacillus. Repeated paracentesis of both joints was done, and various amounts of fluid removed. The fluid was a clear, amber-colored, viscid fluid without sediment, containing some polymorphonuclear leukocytes. The specific gravity was 1.027. A strongly positive Rivalta's reaction proved its exudative nature. Smears and cultures were negative for microörganisms. On July 13 bilateral tonsillectomy was done, and thirteen days later the patient was discharged from the hospital, with normal knee-joints and feeling well. In January, 1933, she had a recurrent hydrops of both knees. Repeated paracentesis again gave relief.

In August, 1933, she consulted one of us (Diepenbrock) at his office on account of lack of appetite, nausea, vomiting, abdominal cramps, loss of weight and constipation. Examination revealed an annular stricture of the rectum too small to admit the examining finger. Proctoscopically the mucous membrane of the rectum was normal up to the margin of the stricture, which was glistening. No masses were present and no induration could be detected. Upon removal of the proctoscope, thick, bloody pus was evacuated. No abdominal masses could be detected. The perineum, vulva, and anus were normal. No masses could be felt vaginally. The uterus and adnexa were normal. No pelvic tenderness could be elicited. The Wassermann once more was negative. There was a slight leukocytosis, and also slight fever. The urine was negative.

On August 24 she was sent to the hospital where, on the 25th, a laparotomy was done. The rectum was found thickened, congested and edematous. Proctoscopically, a section of the stricture was removed; then colostomy was performed. On September 9 she was discharged from the hospital, having gained weight and strength, while the artificial anus performed its proper function.

Histological examination of the tissue removed revealed a dense, granulating tissue with scarring and lymphoid structures resembling the solitary follicles of lymph glands. The epithelium showed no invasive characteristics.

On December 21, 1933, Dr. James J. McGinnis was finally able to obtain a small amount of Frei antigen through the courtesy of Doctors Cole and Conner of Cleveland, Ohio. On the same date both patients were inoculated, intradermally, with 0.1 cubic centimeter on the ventral surface of the right forearm. At the same time a similar inoculation was given a normal person. The next day the two patients revealed at the site of the inoculation a circular area of bluish erythema, approximately 2 centimeters in diameter, in the center of which a firm nodule was noted. The control was negative.

At the present time the patient receives frequent dilatation of her stricture, while the colostomy continues to divert the fecal stream.

The male patient has remained well to date.

450 Sutter Street.

A CASE OF DIABETES INSIPIDUS*

CONTROLLED WITH POWDERED PITUITARY POSTERIOR LOBE EXTRACT APPLIED INTRANASALLY, AS SNUFF

By C. Kelly Canelo, M.D.
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AND
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San Francisco

REPORT OF CASE

THE patient (A. O. L., UCHOPD, No. 207357), a single male, age forty, was in good health until the age of twenty-two, when he contracted typhoid fever. During convalescence he developed polyuria and polydipsia, which amounted to some eight or nine liters daily. The condition persisted up to the time of entering the hospital, November 16, 1931.

His past history, otherwise, bore no relation to his present complaints, nor did the family history.

Physical examination revealed no significant abnormalities. Laboratory investigations showed a normal blood count; normal glucose tolerance curve; negative blood and spinal fluid Wassermann. An x-ray of the sella turcica showed it to be within normal limits, and the skull otherwise disclosed no abnormalities. The Volhardt test gave a concentration of 1.003-1.005-1.004. In other respects, the urine was normal.

During the patient's hospital stay it was found that the fluid intake and output could be maintained at about two liters daily by the administration of obstetrical pituitrin, one cubic centimeter, hypodermically twice daily. Accordingly, the patient was discharged from the hospital on this dosage and transferred to the out-patient department, where he has been observed for the past two years.

During this period various approved treatments were tested in an attempt to find which method would prove most efficient, easily administered, and economical.

The accompanying chart shows the results of the several procedures tried. It was not convenient for the patient to measure his fluid intake; however, since his weight remained stationary, the fluid output can be reasonably regarded as an index of efficiency of treatment.

On one cubic centimeter obstetrical pituitrin hypodermically, twice daily, his fluid output was maintained at from 2,080 to 2,240 cubic centimeters for a period of two months.

The next month, treatment was modified by administering one cubic centimeter surgical pituitrin, hypodermically, *once* daily. On this regimen the polyuria and polydipsia were controlled for from eight to nine hours, followed by a prompt return of excessive thirst and polyuria.

The following month, only one cubic centimeter daily of obstetrical pituitrin accomplished control of symptoms practically identical with his experience, while using the double strength pituitrin S preparation.

Upon resuming the original routine of one cubic centimeter obstetrical pituitrin twice daily, the daily fluid output was again controlled at from 1,920 to 2,240 cubic centimeters.

It was then decided to try, next, powdered posterior lobe pituitary extract, grains one-tenth, as a snuff, to be inhaled three times a day. This procedure maintained his fluid output between three and four liters. Upon increasing the medication to grain one-fifth three times a day, the output was reduced to three liters daily.

Although this dosage was fairly satisfactory, especially during the daytime, the patient was annoyed by thirst and voiding during the night. Accordingly, a fourth dose at bedtime was recommended. This permitted him to enjoy a full night's rest. His output now ranged from 2,080 to 2,240 cubic centimeters.

At this time the patient ran out of funds and was, therefore, forced to stop treatment; whereupon the fluid intake and output promptly rose to from 5,760 to 6,080 cubic centimeters, with the original distressing symptoms of polyuria and polydipsia, together with serious interruptions of sleep as a result. A return to the snuff therapy (powdered posterior lobe pituitary extract) once again controlled the fluid output at about 2,560 cubic centimeters daily.

This was continued until July, 1933, when it was thought desirable to test the effect of amidopyrin, grains five, four times daily. From the chart it can be readily seen that this treatment did not prove satisfactory, for his output promptly rose to between 4,960 and 5,280 cubic centimeters.

Again returning to the treatment with powdered posterior lobe pituitary extract snuff, grain one-quarter, four times daily, his intake and output were controlled at from 1,920 to 2,240 cubic centimeters daily, and have remained within these limits for the past eight months. The patient gets from eight to nine hours of uninterrupted sleep—a "Utopia" for one suffering from diabetes insipidus. There has never been any nasal irritation or other discomfort from his use of the snuff.

COMMENT

In 1913 Farini and Ceccaroni, as well as Veldon, independently demonstrated for the first time the value of injections of posterior pituitary extract in controlling the symptoms of diabetes insipidus. This therapy proved efficient in the case here reported.

Because our patient was in quite limited financial circumstances, and because he found it necessary to tour around from time to time seeking work, traveling by automobile and staying in temporary camps, hypodermic medication was not entirely satisfactory, so it became imperative to search still further in an endeavor to obtain satisfactory control of his ailment.

Pitressin has been demonstrated by Kamm to be more specific than pituitrin; but, as stated above, hypodermic treatment was not feasible. The same objection applied to intermedin.

Motzfeld (1918) reported a case of diabetes insipidus, in which the symptoms were controlled by feeding fresh posterior pituitary lobe of the ox. Rees and Olmstead (1922) successfully controlled a case on desiccated posterior pituitary put up in salol-coated capsules. However, Christian and Blumgart found posterior pituitary by mouth, in salol capsules, or colonic irrigations, ineffective in their cases. Blumgart claimed that it must be administered either by injection or intranasal application—as a spray, saturated pledgets of cotton, or as a snuff powder. He stressed the advantage of the intranasal route over hypodermic medication, since it does not produce the not infrequent distressing side-effects of pituitrin injections, viz., local soreness and swelling at the site of injection, nausea, abdominal discomfort, pallor, palpitation, and syncope.

Mettel (1929) reported a case of diabetes insipidus in a girl, aged nine, who responded to treatment with solution of pituitary dropped into the nose, three times daily, by means of a medicine dropper.

Blumgart controlled four cases by spraying the posterior pituitary liquid into the nose; and in an-

* Read before the Pacific Interurban Clinical Club at the University of California Hospital, San Francisco, December 14, 1934.

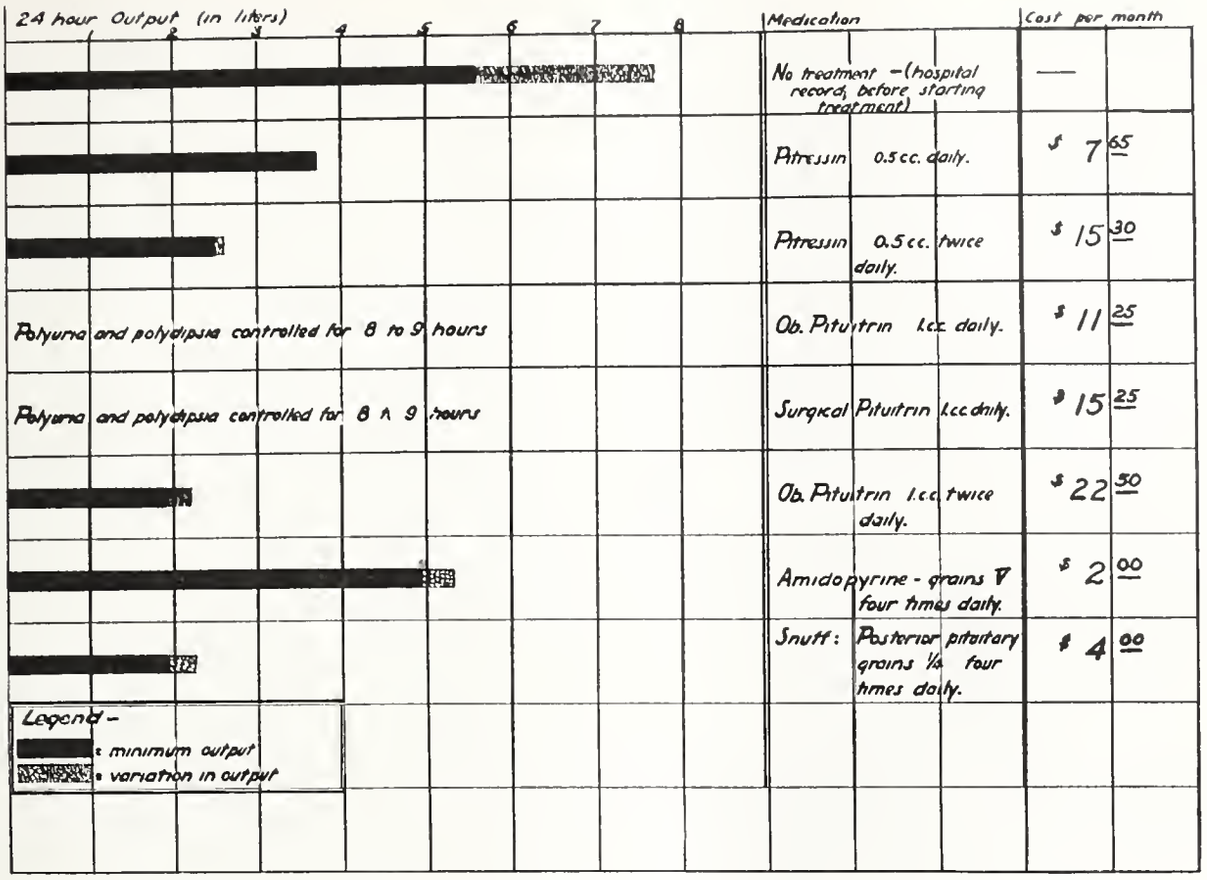


Chart 1.—A case of Diabetes Insipidus showing the efficiency and cost of various medications.

other series of eight cases Campbell and Blumgart were similarly successful with a spray of one-half to one cubic centimeter obstetrical pituitrin, used every three to six hours. In these latter cases the same dosage on a cotton pledget proved equally satisfactory, when introduced into the nose.

Andrey (1924) showed that the symptoms of diabetes insipidus could be relieved by snuffing 50 milligrams of dry powdered posterior lobe pituitary three times daily. Later Rosenberg, Vidgoff and Smith reported cases successfully treated by this method. Vidgoff, in his report, showed that pituitary jelly was less effective and more expensive than the posterior lobe pituitary snuff.

The writers chose the snuff as the method of choice for intranasal administration of posterior lobe pituitary substance, since it offers the most convenient, as well as the most economical means of treatment. Each dose is accurately weighed out and dispensed by the pharmacist in a "powder paper." When it is time to take his medicine the patient simply unfolds the paper, rolls it up similar to a "sipping-straw," inserts one end into the nose, sniffs the powder, and he has no further worries until time for his next treatment. Whether he be in an otorhinolaryngologist's office or traveling along the isolated country highway in his automobile, his medication is administered equally satisfactorily.

Because Scherf, in 1932, and Kahn, in 1933, reported some success in treating diabetes insipidus with amidopyrin, it was deemed appropriate to check its action in our patient; but reference to the chart will demonstrate its inefficacy, at least in this case.

The economy of this efficient and convenient method of treatment becomes apparent in the determination of comparative costs, a point of no mean importance when it is realized that treatment must be continued for life. Our patient, if treated with obstetrical pituitrin, one cubic centimeter twice daily, whether hypodermically or in a spray, will require sixty ampoules per month, at a cost of from $13 to $15. One month's supply of snuff, however, consisting of 120 measured doses of powdered posterior lobe pituitary substance, grain one-quarter, individually wrapped, will cost the patient $4. A rather formidable saving of about $100 per year—and with an equally efficient form of therapy.

CONCLUSIONS

1. A case of diabetes insipidus of eighteen years' duration, which developed during convalescence from typhoid fever, is herein reported.

2. Powdered posterior lobe pituitary substance as a snuff and pituitrin hypodermically controlled the symptoms equally efficiently. Amidopyrin failed to relieve him.

3. The snuff treatment was more easily administered, and strikingly more economical.

4. The literature on the treatment of diabetes insipidus is reviewed briefly.

Medico-Dental Building.

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THE MECHANICAL RESPIRATOR*

A BRIEF SUMMARY OF CASES TREATED AT SAN FRANCISCO HOSPITAL

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OF twelve individuals treated, ten were affected by acute anterior poliomyelitis, in which respiratory paralysis had occurred, and two were affected by measles complicated by postmeasles pneumonia.

In the latter group there was one boy (age, eight years) who recovered, and one girl (age, four years) who died.

Of the former group, there were four males (ages four, twenty-three, twenty-six and fifty-three years) of whom but one recovered (age four years); but this boy was of non-local residence, and it is not known whether finally he recovered. There were also six females (ages sixteen, twenty-two, twenty-two, twenty-three, twenty-six, and twenty-six), none of whom recovered.

In the postmeasles pneumonia cases, the boy was in the hospital forty-eight days, while death in the girl occurred four days after admission.

In the poliomyelitis group the boy who did not die in the hospital in San Francisco, but in whom the ultimate outcome is not known, was treated for only five days, when he was returned to his home by airplane; but the duration of the hospital care given the others varied from less than one day (age fifty-three years) to fifty days (age twenty-three years).

Death, when it occurred after an interval of more than two days' treatment in the respirator, was found to be due to hypostatic or bronchopneumonia. In those instances, however, in which death occurred following a shorter interval, bulbar paralysis was given as the immediate cause of death.

It is believed, therefore, from this brief study of a small series of cases, that there is justification for skepticism toward the actual benefit to be derived from treatment with the respirator or any other type of "mechanical lung." It is certainly evident that life may be prolonged, and this may be sufficient to encourage the use of the device; but little confidence may be placed, it is believed, in the rather remote possibility that the function of the respiratory muscles will return before pneumonia of one or another type develops because of the incomplete aeration, and the effects of the positive-negative pressure phases, including the inadequacy of provision for proper general care and hygiene.

It is not meant to convey the impression that the device is to be condemned or not used, if available. Assuredly it is not a complete substitute for the lost respiratory function. Moreover, its value in suitable cases of acute anterior poliomyelitis even after prolonged use, as far as the final clinical outcome of the disease itself is concerned, appears to be doubtful.

San Francisco Hospital.

How to Prevent Common Colds.—How can we prevent a cold? Since we know that colds are catching, we should make every attempt to avoid close contact with those who have an acute cold. This is particularly important during the first three days of the disease.

Some exposure is unavoidable. There are a few simple rules to follow, however, which probably aid in preventing colds, even if one is exposed. The rooms in which we live should have a suitable temperature and humidity. The superheated air of an office or apartment may reach a temperature of 80 degrees. The air becomes as dry as that of a desert so that the membranes of the nose and throat become parched and cannot perform their normal protective functions. This condition predisposes to colds.

Are Wet Feet Harmful?—The body surface should be kept warm and dry. If the skin becomes chilled, one is apt to catch cold. Mothers worry when their children play in the snow or rain and get their feet wet. Wet feet are not harmful so long as the child is active and exercising, but if a person sits quietly in school or office all day with wet feet, the body surface becomes chilled, thus predisposing to a cold.

Many people believe that alcohol is of value in preventing colds. When one is chilled, alcohol does give a feeling of warmth, but causes flushing of the skin and great loss of heat. If one is continuously exposed to the cold, as on a long drive in freezing weather or working all day in the cold rain, a series of drinks of whisky may do real harm. When one finally comes in from a long, cold trip, however, all wet and chilled, shivering and cold, and does not need to go out any more that day, a reasonable drink of alcohol is of definite value in bringing about a rapid flushing of the skin and a warm, comfortable glow. The same effect may be obtained, though somewhat more slowly, with a hot mustard foot bath and a drink of hot coffee. —Dr. Wilson G. Smillie, Professor of Public Health Administration, Harvard University School of Public Health.

One of the most important lessons that we should appreciate is the great complexity and the vast scope of the field of public health. It is not a definite science but comprises a great body of knowledge about as broad as experimental science itself. For that reason the study of public health should be excellently adapted for general educational purposes. In this field, not only are the fundamentals of practically every laboratory science applied, but here is ample opportunity for the study of classics, the humanities, social problems and economics; for all civilizations have been profoundly influenced by problems of health and disease.—D. J. Davis, M. D.

* From the office of J. C. Geiger, M. D., Director of Public Health, City and County of San Francisco.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

ENDOCRINE PREPARATIONS AND THEIR CLINICAL USEFULNESS

I

THYROID SUBSTANCE

H. Lisser, M. D. (384 Post Street, San Francisco).—One might well wonder how and when the clinical field of hormonotherapeutics would have developed had it not been for the fortunate circumstance, discovered forty years ago (1892), that dried thyroid substance orally ingested utterly transformed myxedematous children and adults. This simply applied and amazingly effective remedy stimulated and buoyed the hopes of those investigators who since then have striven to produce similar successes with preparations from the other ductless glands. Thirty years elapsed before the second marvel appeared, insulin. This again spurred on renewed enthusiasm, and the past decade has witnessed the isolation of several remarkable substances from the parathyroid glandules, the anterior hypophysis, the adrenal cortex, and the male and female sex glands.

For the present, however, and perhaps for some years to come, thyroid substance will remain the most valuable incretory extract of them all, with the widest clinical applications. It is preëminently useful. It is easy to administer and control. Unfortunately, there continues lamentable ignorance of when and how to prescribe it, and injudicious hostility toward it, with misguided propaganda concerning its exaggerated dangers.

Myxedema in full-blown form is relatively uncommon, but probably less so than generally supposed. Hardly another disease can be mentioned wherein such truly miraculous changes may be wrought, and hardly another ailment can be thought of which is so consistently mistaken. If this be true for outright myxedema—and it is true—how infinitely more so does it hold true for the more frequent and less characteristic or partial forms of the disease, and for the milder grades of hypothyroidism!

Considerations of brevity permit only a mere listing of symptoms and signs sometimes caused by inadequate thyroid function. The reader who wishes to pursue this further is referred to a recent article by Lisser.[1]

Circulatory phenomena: Fatigue, dyspnea, orthopnea, bradycardia, "myxedema heart," with dilatation of all chambers and specific progressive shrinkage under thyroid therapy; flattening or inversion of T-waves, sometimes in all three leads; abnormal axis deviation, small P, notched and widened Q. R. S. complexes, quite common; moderate hypertension; even heart-block and hydrothorax.

Gastro-intestinal phenomena: Constipation, even obstipation, achlorhydria, abdominal pain, hepatic dysfunction, diatheses of infancy (vomiting, intestinal colic, etc.), and even megacolon and ascites. Anemia with weakness and weariness is a common symptom. This hypothyroid anemia may be quite severe, occasionally with high color index, and frequently with achlorhydria, leading to a diagnosis of atypical pernicious anemia. Such patients may have a pasty, slightly yellowish complexion, sometimes with a malar flush.

Arthritic symptoms, such as achiness and stiffness in various joints or muscles, are not uncommon manifestations of hypothyroidism.

Menorrhagia and metrorrhagia may be the presenting complaint. Atony of the urinary bladder has been reported in myxedema, and relieved by thyroid substance.

Puffiness of the eyelids, impairment of hearing, giddiness, vertigo, tinnitus aurium, snuffles, chronic hoarseness—any one of these may be consequent to thyroid deficiency.

Roughness and dryness of the skin, absence of perspiration, coarseness and loss of hair, sensitiveness to cold weather, even icthyosis, keratodermia, pruritus, alopecia, and onychauxis may have a hypothyroid basis.

Mental torpor, forgetfulness, inattentiveness, loss of initiative, stupidity (especially in hypothyroid children), lethargy, drowsiness, apathy, clumsiness, and even severe melancholia, mania, hallucinations and delusions may depend on thyroid inadequacy.

Dwarfism may be a striking characteristic of childhood myxedema. Obesity is a common finding in children and adults with low basal metabolic rates. Even allergic states have at times been relieved by thyroid substance.

This kaleidoscopic array of symptoms illustrates the capricious vagaries of hypothyroidism. Many of them may occur in one individual; more often only a few are present and so dominate the patient's complaints that the physician is led astray, and the underlying common denominator of thyroid failure is unrecognized. It is important, therefore, to keep in mind these hidden hints of myxedema, since they respond so satisfactorily to thyroid therapy.

[1] Lisser, H.: The Clinical Indications for and the Proper Use of Thyroid Substance, International Clinics, Vol. IV, Forty-Third Series (December), 1933.

Thyroid substance has been therapeutically helpful in some conditions not necessarily of thyroid origin, such as parathyroid tetany, progressive axial myopia, thrombo-angiitis obliterans, lipoid nephrosis, asthenic states, and nonthyroid obesity.

Basal metabolic rate determinations, roentgenographic determination of bone age in children suspected of hypothyroidism, and blood cholesterol values, are helpful technical aids in diagnosis and in controlling treatment, but must be interpreted in conjunction with the anamnesis and physical examination and clinical response to treatment. The blind acceptance of a laboratory report may lead to serious error. The physician must be self-respecting enough of his clinical legs to stand on them firmly, and not be swept off his feet by a laboratory test. A markedly subnormal basal rate does not, *ipso facto,* signify hypothyroidism; nor does a normal rate necessarily exclude it.

It is obvious that thyroid should never be administered to an individual who is already suffering from too much of it. Why add fuel to the flames?

It probably makes little difference which brand of thyroid, thyroxin, thyreodin, or thyractin, etc., the physician selects, since all of them are potent, so long as he sticks pretty well to one of them and becomes intimately familiar with its action. There is such a thing in clinical practice as "getting the feel" of a preparation, and from long experience gauging fairly accurately the appropriate dose for a given degree of thyroid deficiency in a particular type of patient.

Remember that one grain of the "desiccated substance" is equivalent to approximately five grains of the "fresh substance."

Begin with a relatively small dose, such as one-half grain of the desiccated substance once or twice daily; increase gradually and keep your patient under weekly observation until you have reached the proper maintenance dose.

At first thought one would expect to be guided in estimating the proper dosage by the depth of the basal rate—that is to say, the more subnormal the rate the larger the dose; but this concept is quite erroneous. Indeed, the opposite is more nearly correct. The greater the basal depression and the more profound the myxedema, the more delicate the response to thyroid substance. Patients with frank myxedema and basal rates of 30 to 50 minus are quite susceptible to relatively small doses of thyroid extract, and rarely require more than four grains daily of the desiccated substance to elevate the rate to a normal level; and usually two grains daily suffice to maintain it there.

The following symptoms should excite suspicion of overdosage: Nervousness, excitability, fidgetiness, irritability, insomnia, excessive perspiration and feeling of heat, palpitation and dyspnea, subjective sensation of pounding and racing heart action, diarrhea, scanty menses or prolonged menstrual intervals, especially if these symptoms are new phenomena, or, having existed before, are now materially increased. Objective confirmation is furnished by undue loss of weight, toxic appearance with anxious staring eyes, agitated demeanor, undue talkativeness, tachycardia, forceful heart action, rapid fine tremor of the extended fingers, enlargement of the thyroid gland with thrill and bruit, and elevated basal metabolic rate—in other words, the symptoms and signs of hyperthyroidism. The appearance of any one or a number of these constitute a signal for decreasing the dose and, still better, discontinuing thyroid entirely for a few days or a week. There is no occasion for alarm on the part of either patient or physician, since the disagreeable symptoms will promptly vanish in from three days to a week, unless the toxic state has been permitted to continue for many weeks before a halt was called. After the toxic manifestations have subsided, thyroid should be resumed; but, of course, at a lower dose than the amount which provoked toxicity.

All of which means that no patient should be permitted to continue taking thyroid without remaining under periodic observation.

It is wise to warn all patients to report any new symptoms at once, and if they are at a distance which prevents their calling promptly, to discontinue the thyroid temporarily, especially during intercurrent infections with fever.

When vacation time approaches, or whenever patients are leaving on extended trips which may take them into great heat or altitudes over 3,000 feet, it is prudent to cut the dose in half at least, and sometimes to omit thyroid altogether. The same precaution is taken if any exceptional physical, mental or emotional strain is impending. Reference is made to such episodes as an athletic contest or tournament, an operation, college examinations, intense business conferences, marriage ceremony, serious illness or death of a close relative, etc.

It is time to stem the tide of exaggerated fear of this valuable hormone which has obsessed a considerable part of the medical profession for the past twenty years. No potent drug is harmless, but thyroid administration is one of the simplest to control. The profession is responsible for instilling and fanning alarm in the public. It is diverting to notice how often we turn out to be our own worst enemies.

It is high time that the public's blaze of fear concerning thyroid therapy (by a physician) be permitted to consume itself; indeed, some quenching of it, and even some back-fire, by ourselves, would not be inappropriate.

* * *

EXTRACT OF ADRENAL MEDULLA

FLETCHER B. TAYLOR, M. D. (400 Twenty-ninth Street, Oakland).—Epinephrin is one of the few potent biologic products. It can be synthesized, but the best source for commercial purposes is the medulla of the adrenal glands of beef. Its

usefulness lies in its power to activate involuntary tissues, as if sympathetic nerve supply to such tissues were being stimulated. It relaxes bronchial spasm, lessens gastro-intestinal peristalsis, increases the available sugar in the blood, raises the blood pressure, and controls urticaria in some of its useful physiologic expressions. How may it be used effectively, and what are the dangers involved?

1. When applied to mucous membrane, it shrinks the membrane, blanches it, decreases the flow from bleeding points, checks the discomfort caused by allergens, is not absorbed to any great extent by circulating body fluids, and is not dangerous.

2. When used subcutaneously it has local effects similar to those just described, but it is made available to body fluids by this route. It has, therefore, systemic effect when thus given. But still it is not dangerous in ordinary doses. Dr. Chauncey Leake reports that there are no deaths recorded in recent years from the subcutaneous injections of epinephrin alone. One-quarter milliliter of the usual 1-1000 dilution is a small dose; one milliliter is a fairly large one.

3. When used intravenously or when injected into heart muscle, both the power and danger are multiplied by twenty, as compared with avascular injection. One milliliter of 1-1000 epinephrin will kill a two-kilo rabbit when given intravenously. The mechanism of death involves rise in blood pressure and the development of lung edema.

How may epinephrin be used safely by vein in the treatment of serious shock?

What patients are poor subjects for intravenous injection of epinephrin?

4. A young person with good heart muscle, who has obvious shock following surgical operation or injury, may be sometimes saved from death by the intravenous injection of one to four milliliters of epinephrin, diluted in physiologic saline solution and injected during a total period of one hour or more.

5. An elderly person with poor heart muscle may be killed by the procedure just outlined. But if the condition is surely one of shock and not of heart failure, a smaller amount per unit of time may be used despite the risk involved.

What of the mixture of epinephrin with local anesthetic?

6. This is a very convenient mixture for the surgeon, but the toxic effects of the anesthetic are increased in the presence of epinephrin.

7. Large amounts of such mixtures are used with impunity in surgical work about the abdomen or extremities.

8. The surgeon who works with submucous injections, *e. g.,* in the nose, the mouth or the gums, may well assume that he is making intravenous injections of his material. That attitude of mind may save unnecessary reactions and accidents.

The patient whose tolerance is doubtful should have a test dose given on a day separate from the day of operation. After the dose, blood-pressure readings and observations for lung edema can be taken and recorded at fifteen-minute intervals for an hour. This will help in the recognition of those patients who have bad psychic or physiologic reactions.

Two other practical considerations may be worth mentioning:

9. A potent solution of epinephrin is white or straw-colored. Oxidation changes it to a garnet color and makes it useless. A sealed ampoule of white glass protects the solution and allows its color to be easily seen.

10. A one-ounce, corked bottle of 1-1000 epinephrin solution costs the doctor about one dollar. Synthetic epinephrin costs about one-half as much and is about one-half as potent. Single milliliter ampoules increase the cost threefold over the cost by the ounce. The corked-bottle content deteriorates more rapidly than the ampoule content, and is less certainly sterile, despite the presence of five-tenths per cent chloreton. Why may not epinephrin solution be carried in the vaccine type of bottle with rubber cap, thus combining the three advantages of sterility, prolonged potency, and economy?

EXTRACT OF ADRENAL CORTEX

The only commercially available product of adrenal cortex which has a proved potency is the "Eschatin" of Parke-Davis. This costs, to the doctor, $6 per ten milliliter bottle. Its most practical value is to the patient with Addison's disease in a period of acute relapse. It may then be given by vein in amounts from 10 to 50 cubic centimeters, and has often saved lives when thus used. But what of the use of maintenance doses for those patients who are chronically disabled over long periods? One or two milliliters, three to seven times per week, have been used with variable success between relapses. Dr. Hans Lisser computes the cost at or near $1,000 per year for patients observed by him. This makes it economically impossible for the average patient. There are other discouraging features in its use. Steady maintenance dosage usually requires gradually increasing amounts. Dr. William Fitch Cheney has had the most cheerful experience known to me, having maintained a patient with Addison's disease in good health for three years with a daily dose of two milliliters. The efficacy of the extract may be enhanced by Doctor Harrop's plan of encouraging the free use of sodium chlorid at the table, plus one to seven grams daily in capsules. Eschatin is intolerably painful to some patients when given into the muscle. I know of no accidents from its use in the vein.

* * *

PARATHORMONE

H. Clare Shepardson, M.D. (384 Post Street, San Francisco). — Although Sandstrom (1880) first specifically described the superior or external pair of parathyroid glands, he left unsettled their

possible physiological function. Later (1891) Gley rediscovered the superior pair and instituted a notable series of experiments to determine their functional pathology.

In spite of his erroneous idea that the parathyroids could compensate for the extirpated thyroid gland by differentiating into thyroid tissue, Gley's experiments provided two important results. An explanation was afforded for the difference in the results of thyroidectomy in carnivora and herbivora. In the latter, due to the anatomical location of the parathyroid glandules, tetany was usually escaped following thyroidectomy. Of even greater importance, however, numerous investigations were stimulated to attack various problems relating to the parathyroids.

Thus Kahn (1895) is credited with the actual discovery of the inferior or internal pair of parathyroid bodies and, furthermore, he was the first to insist that these glandules are organs anatomically separate and functionally distinct from the thyroid gland. In the following year (1896) Vassale and Generali demonstrated a definite relation between extirpation of the parathyroids and the convulsive attacks known as postoperative tetany which occasionally followed subtotal thyroidectomy. These observations were eventually confirmed by the work of Nicholas and Swingle (1924), which afforded conclusive evidence that complete removal of the parathyroid glands results directly in a specific syndrome of symptoms and death. As a result, "tetania thyreopriva" became "tetania parathyreopriva." Any doubt which may have existed subsequent to this latter work was completely removed by the masterful researches of Collip, culminating in the isolation by him (1925) of a potent parathyroid extract. This extract contained the active principle of the parathyroids, and injections of the substance uniformly prevented or relieved tetany in thyroparathyroidectomized dogs. Collip was, therefore, able to offer confirmatory evidence to the ideas expressed by MacCallum and Voegtlin, as far back as 1909, that the function of the parathyroid glands is to regulate the calcium exchange in the body. These writers considered that all the symptoms following parathyroidectomy were due to calcium deficiency, and Collip showed that the probable manner of action of the parathyroid hormone is through a direct effect on calcium metabolism. The use of this extract restores to normal the abnormally low-blood serum calcium of tetania parathyreopriva. Furthermore, the injection of this extract into normal dogs causes an elevation of the blood serum calcium value and, if continued, causes death from hypercalcemia.

The discovery and preparation by Collip of the hormone of the parathyroid glands have afforded in recent years an opportunity for diverse and elaborate investigations concerning its physiological properties. All authorities are at present agreed that its chief rôle consists in its important influence on calcium and phosphorous metabolism.

In the matter of the injection of parathyroid extract, Collip produces four cardinal effects: (*a*) rise in serum calcium; (*b*) rise in urinary calcium excretion; (c) fall in serum phosphorus; and (*d*) rise in urinary phosphorus excretion. Contrariwise, it has been shown that parathyroidectomy results in (*a*) fall in serum calcium; (*b*) fall in urinary calcium excretion; (*c*) rise in serum phosphorus; and (*d*) fall in urinary phosphorus excretion.

Inasmuch as the characteristic rôle of the parathyroid hormone, in relation to calcium metabolism, is mobilization, the chief source of calcium supply in the body should be mentioned. Aub and his co-workers have demonstrated that a long-continued high calcium diet results in an accumulation of calcium in the trabeculae of bone. On the other hand, prolonged administration of parathormone depletes this storehouse of readily available calcium. Apparently easily mobilizable calcium is not deposited in the bone shafts of adult animals.

At present seven diseases are recognized as associated with disturbance of calcium metabolism: Graves's disease, nephrosis, steatorrhea with megacolon, infantile rickets, osteomalacia, generalized osteitis fibrosa cystica, and tetany. Of these, probably only two are associated with lesions of the parathyroids—parathyroid tetany and its antithesis, osteitis fibrosa cystica (von Recklinghausen's disease).

Whether other systems and organs of the body, besides the nervous and osseous systems, are involved in disturbances of parathyroid function, is not settled at present. The evidence so far is conflicting as to whether the parathyroids are concerned with carbohydrate metabolism, or with liver function. There is a similar uncertainty in regard to the influence of the parathyroid hormone on gastric secretion and intestinal activity.

Parathyroid extract, Collip, is commercially available under the name "Parathormone." It is supplied in ampoules containing a certain number of "units per cubic centimeter." A unit of potency has been defined as 1-100 of that amount of extract which produces, on an average, a 1 milligram rise in blood serum calcium in 10 to 12 kilogram dogs over fifteen hours. It is injected subcutaneously or intravenously. There may be slight burning or pain at the site of injection (never severe), and sometimes the patient complains of abdominal cramps; otherwise, no unpleasant or ill effects are noted. The dose must be carefully controlled not only by the state of the patient, but more specifically by repeated accurate determinations of the blood serum calcium. The latter should not be permitted to rise to dangerous heights, for massive doses or repeated injections at short intervals produce a hypercalcemia in dogs which, if maintained, results in death. This extract cannot be given carelessly any more than one may trifle with insulin.

Parathormone is not efficacious when administered by mouth.

At present sufficient clinical investigations with this active parathyroid extract have been recorded to indicate its usefulness and specificity in tetany. Adequate evidence of its effectiveness in tetania parathyreopriva (postoperative tetany) has been recorded by Crile, Snell, and Lisser and Shepardson. Davidson has reported its use in a case of chronic tetany associated with myxedema and nephrosis. Collip and Leitch used it successfully in a case of tetany in a young child, and Hoag and Rivkin recorded its satisfactory effect in four cases of infantile tetany. Lisser, Smith, and Shepardson obtained brilliant improvement in a severe case of tetania gravidarum.

In addition to those pathologic conditions associated with hypoparathyroidism, or with lowered blood serum calcium resulting from parathyroid deficiency, parathormone has been used with considerable success in certain other abnormal states. Thus, a noteworthy advance in the treatment of lead poisoning has been contributed by Aub and Hunter. They found that the administration of parathyroid extract proved to be a more efficient and more rapid means of increasing the elimination of lead than any method heretofore employed. Likewise, parathormone injections, controlled by serum calcium estimations, markedly increased the elimination of the radioactive material, via the stools, in three cases of radium poisoning occurring in luminous-dial painters.

Huefer observed that parathormone has a strong vagotonic effect, causing a decrease in the pulse rate, prolongation of the cardiac systole, shortening of the diastole, hyperemia of the vessels of the abdominal organs. When the dosage of parathyroid extract is adjusted in such a way that the blood calcium level is raised to about 15 milligram per cent, a markedly increased excretion of urine may occur. Other workers have utilized this diuretic effect to advantage in such conditions as nephrosis, nephritis with edema, ascites as well as in eclampsia and allied conditions.

Parathormone has been employed in many other conditions, but the evidence accumulated to date is too fragmentary to be convincing.

It is difficult to give directions as to dosage. This must be individualized. The age and weight of the patient, the severity of the symptoms and the level of the blood serum calcium, constitute the data which should influence estimation of the dose. It is wiser to spread the effect over twenty-four hours by three or four injections at intervals of six to eight hours, rather than to administer one massive dose daily. Early in the course of the disease seven to fifteen units of parathormone daily will ordinarily elevate the depressed blood serum calcium occurring in tetany to a normal level and maintain it there. With adequate control of the blood calcium, larger doses may be given. In such conditions as lead poisoning, the dosage used has varied from twenty to one hundred units daily.

Since the chief object of the administration of parathormone, in most instances, is the maintenance of a normal amount of circulatory calcium, it is usually wise to make available an adequate supply of calcium by means of its oral administration. Any soluble salt is obviously more assimilable than the phosphate or carbonate. Calcium lactate is the preparation ordinarily used, the dose varying from one to fifteen grams daily, although larger amounts are tolerated surprisingly well.

Finally, a word of caution should be added. In severe tetany the response to parathormone is a sensitive one, *i. e.,* the blood serum calcium will be affected by a much smaller dose than would be the case in a normal individual. Consequently, the law of specific hormone therapy, "a patient's sensitiveness to a given hormone is in direct ratio to the need thereof," applies to parathormone just as it applies to other active gland extracts.

* * *

INSULIN

E. Kost Shelton, M. D. (34 West Micheltorena Street, Santa Barbara).—The discovery of insulin, a story too well known to be repeated, marked a major turning point in the history of medicine. While it was previously conceded that health was dependent upon a balanced biochemistry, it remained for Banting and his co-workers to show the full import of this dictum. Up to this time diabetes mellitus, a particularly dread disease, had continued to stalk its prey relentlessly. The disorder was particularly fatal in children and thousands, administered to by a helpless profession, died before their time. One can appreciate what a profound effect the announcement of a "cure" for diabetes had upon physician and layman alike.

Those of us who were fortunate or unfortunate enough to have been in active practice at this time felt or rather hoped that insulin would prove to be a specific for diabetes. In other words, we were expecting a cure. It was not long, however, before this hope was definitely abandoned; for while insulin soon revolutionized the treatment of diabetes mellitus, one as readily learned of its limitations. This, of course, did not detract from its therapeutic importance, but led rather to deeper and more comprehensive studies in which insulin survives as an even more versatile boon to humanity. Carbohydrate metabolism, a subject which had baffled investigators since the time of Claude Bernard, became more thoroughly elucidated in the light of this discovery, and with it the knowledge that insulin is but a link in an endless physiological chain.

It has been shown that this remarkable hormone is dependent in a large measure upon other internal secretions for its degree of activity. Its secretion and effect are likewise subject to diet, exercise, the condition of the liver, the rate of absorption and elimination of foodstuffs, and last but not least, psychogenic factors. None of these complicating elements minimize the clinical usefulness of insulin, however—quite the contrary.

They, in turn, are dependent upon the active principle of the islands of Langerhans. Thus, insulin steps out of its heroic but rather limited rôle in the body economy and assumes a broader and more useful therapeutic position.

What is the present status of insulin in clinical medicine? In my mind, its usefulness may be roughly classified as follows:

1. In the treatment of diabetes mellitus and its complications.
2. In the treatment of underweight but otherwise normal (?) individuals.
3. In the treatment of individuals debilitated by disease or following serious operations.
4. In diagnostic procedures.

1. *In the Treatment of Diabetes Mellitus and Its Complications.*

While the use of insulin in diabetes mellitus is well known to the average physician, a few remarks concerning its indications are in order. Given a patient in whom a tentative diagnosis of diabetes mellitus has been made, what should be the physician's procedure? He has the choice of either referring the patient to a diabetes specialist for an initial observation period, or of retaining the patient for himself. If the physician is passably familiar with carbohydrate metabolism in general, and the diagnosis and treatment of diabetes mellitus in particular, there is no reason why he should refer his patient; if he is not, there is every reason. Insulin is a potent hormone and, like all good things in medicine, has also the power to do harm.

Previously an individual presenting sugar in the urine was considered unquestionably as diabetic. Now we know that, in many instances, this is not true. Some individuals have low renal thresholds to sugar and may excrete sugar when the blood values are abnormally low. To give insulin to such an individual is not only poor medical practice, but actually dangerous. Therefore, one must depend upon blood sugar determinations. A blood glucose estimation on a fasting stomach (from twelve to fourteen hours after a meal) is informative in severe diabetes. A blood glucose taken two and one-half hours after a high carbohydrate breakfast (no specified amount) is more informative in a borderline case. But a glucose tolerance test is more or less conclusive. I say conclusive, but I do not necessarily mean that every individual possessing a low glucose tolerance (high blood sugar) is suffering from diabetes mellitus. The test is conclusive only in that it shows inadequate utilization of carbohydrate. Other disorders beside pancreatic dysfunction, *i. e.*, hyperthyroidism, hyperpituitarism, hyperadrenia, interfere with the metabolism of glucose and present just such a laboratory finding. If the diagnosis of pancreatic insufficiency or true diabetes mellitus is ultimately arrived at, one should have no fear of insulin. It is my belief that in this capacity too little insulin is employed.

I shall not attempt, in this brief article, to outline the treatment of diabetes mellitus. Suffice it to say that, in general, if a patient can be kept on a well-balanced and adequate diet, without showing blood glucose values over 150 milligrams per 100 cubic centimeters or acetone, and diacetic acid, or sugar appearing in the urine, insulin is obviously not indicated. If, on the contrary, the patient cannot be kept on a maintenance diet or one even slightly in excess of the maintenance level without producing these evidences of a physiological breakdown, insulin is definitely indicated. Never restrict the diet below adequate levels for the maintenance of health in order to avoid giving insulin. Such a procedure is inexcusable.

In diabetic coma insulin must always be given, quickly and in large doses. In all other diabetic complications, many of which are rarely seen in this age, insulin should take precedence over all other treatment, to be followed, of course, by suitable dietary and all other general and local measures designed for relief.

2. *In the Treatment of Underweight, but Otherwise Normal (?), Individuals.*

Insulin of late has come into great favor as a stimulator of general metabolism in the treatment of the so-called typhus asthenicus or underweight individual. Many of these persons are free from objective evidence of disease. For cosmetic reasons or for relief of a vague train of symptoms, so commonly encountered, it has appeared advisable to raise their weight. This has been accomplished through dietary measures in the past with indifferent success. Insulin has developed into an important aid in such a regimen. Here again one should know something of the individual biochemistry before beginning treatment. I have repeatedly seen thin individuals who were already suffering from mild hypoglycemia (probably due to oversecretion of insulin) given additional insulin without a basic carbohydrate study. The result must be obvious. One such patient was given insulin daily by her physician before luncheon and allowed to leave his office and return to her home several blocks away. She had insulin shock and fainted in the street on two occasions. Her carbohydrate tolerance was found to be high.

After such a study, if there are no contraindications, insulin is indicated. Starting with four or five units, two or three times a day, a half-hour before meals, to test the individual susceptibility, the dose can usually be raised within a few days to ten or even fifteen units. We rarely go beyond ten. The patient is advised to eat always within a half-hour after taking the insulin, and to carry candy or lump sugar with him at all times. Hypoglycemic symptoms of a mild degree are frequent, but not alarming. Real shock is rarely encountered. The diet should be elevated, although this is usually spontaneous, from the increased appetite. Malnourished children are particularly responsive to this type of management, but the dose, of course, must be regulated according to age. The weight gain is slow. Approximately 50 per

cent of adults relapse to the former weight level some weeks after the insulin is withdrawn, but on the whole the treatment is definitely worth while.

3. *In the Treatment of Individuals Debilitated by Disease or Following Serious Operations.*

Everything that has been said under the previous heading pertains here as well. Special caution is necessary, however, since every disease entity and the physical status of each individual present a different therapeutic problem. Persons suffering from tuberculosis, the psychoses, narcotic addiction, the anemias, postinfectious processes, kidney, and other disorders, have benefited from the intelligent application of the insulin regimen. Of course, there is no specificity as regards any of these conditions, only the beneficent effect of an improved metabolism.

4. *In Diagnostic Procedures.*

It has been shown, by numerous observers, that persons suffering from Addison's disease, pituitary cachexia, and other hypoactive pituitary states and severe hypothyroidism, with or without myxedema, are particularly sensitive to insulin. The carbohydrate tolerance is frequently but not consistently elevated (low blood sugar). The reverse is true in hyperadrenia, active acromegaly, and other hyperactive pituitary states, particularly in toxic goiter. Many of these latter have diabetic blood-sugar curves. When the diagnosis is difficult, a not infrequent occurrence in debilitated individuals with a rather vague symptomatology, insulin is frequently a diagnostic tool of considerable value. No definite conclusions may, as yet, be drawn from an individual susceptibility or tolerance to insulin, but I have seen at least one borderline case of Addison's disease and one of pituitary cachexia (both later verified) in whom susceptibility to insulin gave early major diagnostic clues.

John of Cleveland has recently reported the treatment of an individual suffering from hyperinsulinism, in whom small doses of insulin before meals apparently rested the pancreas and retarded the natural insulin outflow. The treatment was attended by considerable clinical relief. This use of insulin, on account of its rather revolutionary and paradoxical nature, was not included in my original outline. Our recent work in giving sugar to underweight children one hour before meals in order to stimulate the production of insulin and thereby increase the appetite would tend to confirm John's observation in a roundabout way. At any rate, such a use of insulin must be considered.

In closing I wish to point out that occasionally one discovers an individual who is sensitive to insulin on an allergic basis. While this should be considered, it should not create undue apprehension. Persons are susceptible or unsusceptible to insulin according to their make-up and individual biochemistry. No rule of thumb can be laid down as regards dosage in any type of person or disorder.*

* Part II of this symposium on "Endocrine Preparations and Their Clinical Usefulness' will be printed in the April issue of this journal.

INGBER RESOLUTION NO. 2 *

WHEREAS, The studies of the Committee of Five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

WHEREAS, Because of this economic situation proper medical care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; now, therefore be it

Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital;

2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system;

3. There shall be no provision for cash benefits;

4. The patient shall receive adequate treatment and his physician shall receive adequate compensation;

5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession; and be it further

Resolved, That the California Medical Association immediately offer its full aid and coöperation to the Interim Committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurace system at the 1935 session of the California Legislature shall contain the above principles; and be it further

Resolved, That there be formed a special committee authorized and empowered to act herein, constituted as follows: the Legislative Committee of the Association and three members of the Association to be appointed by the Speaker of the House.

Susceptibility to Colds Varies.—Are drafts likely to produce colds?

Yes, certainly in a susceptible individual. Here again it is a question of chilling of the body surface. A man can work all day in a strong, chilly wind, and if active and warmly clad, he will not catch cold; on the other hand, a person may be working quietly in a warm, still room with a constant draft of not very cold air on the back of the neck. In susceptible persons this may produce a cold.

Is it possible to harden oneself so that one does not feel the cold? Yes, certainly. Crippled children in chronic hospitals are trained to live outdoors, almost naked, winter and summer.

Many persons take cold baths to harden themselves against sudden changes in temperature. They feel perfectly sure that this method prevents them from catching cold. Cold baths are certainly stimulating, but it must be remembered that they are without benefit unless they are followed by a good reaction with flushing of the skin and a feeling of warmth.

Just as we have gone through the painful process of hardening our bodies against cold weather by gradual exposure to cold, sleeping on outdoor porches and taking cold baths, the skeptical scientist comes along and tells us that there is not the slightest evidence that any or all our efforts have the least effect in preventing us from catching cold.—Dr. Wilson G. Smillie, Professor of Public Health Administration, Harvard University School of Public Health.

* Editor's Note.—This is Ingber resolution number 2 as revised and adopted by the California Medical Association House of Delegates on March 3, 1935. See also page 202 in this issue, for discussion thereon.

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Leaflet Regarding Rules of Publication.— California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

IMPORTANT ACTION TAKEN BY THE C. M. A. HOUSE OF DELEGATES AT THE SPECIAL SESSION ON MARCH 2-3

Action Taken by House May Mean Radical Changes in Practice in California.—At the special session of the House of Delegates held at Los Angeles on Saturday and Sunday, March 2 and 3, policies were adopted which, should they be enacted into law by the California legislature, now in session, might radically change the form of medical practice in the Golden State. The House of Delegates at last year's annual session of the Association at Riverside authorized a medical economic survey of California, and recommended a special session of the House to consider the report of the survey committee, otherwise known as the Committee of Five. The Council issued the call for this meeting and designated the dates, as above, and the place as the headquarters building of the Los Angeles County Medical Association.

The Members of the House of Delegates Were Alert to Their Responsibilities.—We remember not a single meeting of the House of Delegates during the last twenty-five years, in which the presentation of viewpoints by delegates was made in such earnest, clarifying and courteous manner. Radical differences of opinion on the subject of sickness insurance were clearly in evidence from the first call to order, but all who spoke did so without the injection of personalities, the delegates listening with marked attention for one whole day before proceeding to vote on the different resolutions. All present seemed imbued with the tremendous seriousness and importance of the work before them, and of the heavy obligations they assumed for their five thousand fellows of the California Medical Association, on whose behalf and in whose name they were acting.

* * *

The Resolution Incorporating Major Recommendations.—The resolution incorporating the major issues under special discussion was introduced by Dr. Irving Ingber of San Francisco and appears on page 187 of this issue of CALIFORNIA AND WESTERN MEDICINE, where it will be noted that the House of Delegates laid down certain principles to be included in any proposed sickness insurance legislation, designed to protect medical practice and standards. The responsibility of presenting the viewpoints of the Association to the Senate Interim Committee (Senator Dan E. Williams of Jamestown, chairman; Senator Edward H. Tickle of Carmel and Senator Leonard Joseph Difani of Riverside), was given over to a new committee of six members, consisting of the standing Committee on Public Policy and Legislation (Dr. Junius B. Harris, chairman, of Sacramento, Dr. Fred R. DeLappe of Modesto and Dr. E. T. Remmen of Glendale), and three additional members of the Association to be appointed by the Speaker of the House. Speaker Pallette later announced that he had so named Doctors Walter B. Coffey, T. Henshaw Kelly and Joseph Catton, all of San Francisco.

Before announcing the above appointments, Speaker Pallette received and gave careful consideration to many written and oral communications, and the committee as finally announced by him on March 9 was suggested by several of the strongest proponents of the Ingber resolution. It was pointed out that the committee should not only include members who had been much in favor of the action taken by the House of Delegates, but physicians whose affiliations at Sacramento would be of value in promoting the passage of legislation agreed upon, and who lived sufficiently near the Capital to make conferences possible and convenient.

It was also decided to appoint an advisory group to the Committee of Six whose members would be kept in touch with the work in hand, and who could be called upon for active aid, as required. On this advisory committee, up to the time this copy is sent to the printer, are the following:

*Editor's Note.—Copy for the March issue of CALIFORNIA AND WESTERN MEDICINE, inclusive of all editorials except the first on "Important Action Taken by the California Medical Association House of Delegates, at the Special Session, March 2 and 3," was sent to the printer on or before February 20, at least some ten days prior to the special session.

Rodney A. Yoell,* San Francisco; Clarence G. Toland, Los Angeles; Harry H. Wilson, Los Angeles; Robert A. Peers, Colfax; Dewey R. Powell, Stockton; Irving S. Ingber, San Francisco; R. Langley Porter, San Francisco; Loren R. Chandler, San Francisco; Frederick N. Scatena, Sacramento; LeRoy Brooks, San Francisco; Louis Albert Packard, Bakersfield; Henry Dietrich, Los Angeles; John Hunt Shephard, San Jose; A. J. Scott, Jr., Los Angeles; W. W. Roblee, Riverside; Lyell C. Kinney, San Diego; John H. Graves, San Francisco; and George Dawson, Napa.

* * *

Preliminary Reports of the Committee of Five.—The Committee of Five, appointed after last year's Riverside Annual Session and consisting of Doctors William R. Molony, chairman, Los Angeles, Harry H. Wilson, secretary, Los Angeles, Alson R. Kilgore, San Francisco, Robert A. Peers, Colfax, and Rodney A. Yoell of San Francisco, brought in two preliminary reports, copies of which were sent in February to all delegates and component county societies. Much work is still to be done before the final report of the Committee of Five is completed, but it is hoped that it may be finished in time for consideration at the Yosemite Annual Session on May 13-16. In this issue we are printing, on page 160, for the information of members of the Association, some excerpts from the First Preliminary Report. This report was submitted to the Committee of Five by its Survey Staff (Paul A. Dodd, Ph. D., director).

* * *

Minutes of the Special Session Should be Read by Every C. M. A. Member.—A perusal of the minutes of the special session of the House of Delegates, to be found on page 194, will reveal that the die has been cast. Prior to voting on the resolutions, the delegates virtually agreed that, regardless of personal beliefs, Association members should work as a unit, to attain the objectives adopted. Every member of the California Medical Association, therefore, should read carefully the digest of proceedings printed in this issue, because a clear understanding of what has been proposed, as the best solution at hand on the medical economic problems confronting the profession, is of the utmost importance. The Council voted that the March issue of California and Western Medicine should be delivered to its readers two weeks later than its regular date of mailing, so that every member of the Association might be able to better visualize what had been done and is now before us.

* * *

Session Remarkable for Its Kindly Atmosphere.—In bringing these comments to a close, the thought may be expressed that the headquarters building of the Los Angeles County Medical Association, with its quiet and restful atmosphere, was a real factor in promoting the amenities of courteous interchange of thought and fellowship that were so much in evidence throughout the two-day session, as has been happily expressed in a resolution.

In conclusion, it is to be hoped that delegates from the county societies may use the reports* in this issue as a basis for general discussion at early meetings of their respective groups.

A. M. A. HOUSE OF DELEGATES AND HEALTH INSURANCE

The American Medical Association Special Session Report Is Printed in This Issue.—On page 207 of this number of the official journal appears the complete report of the Reference Committee of the House of Delegates of the American Medical Association, as submitted at the special session which was held at Chicago on February 15 and 16.

As is well known, the American Medical Association House of Delegates is composed of representatives from each of the constituent state associations; the apportionment rules permitting, for example, the five thousand members of the California Medical Association to have seven delegates. In every particular, the House of Delegates of the American Medical Association may be stated to be composed of a group of physicians who are truly representative of the more than one hundred thousand medical men making up the membership of the national organization.

The House of Delegates was in special session for two full days, the business to be transacted being

"limited to the consideration of the social and economic policies of the Association, as related to pending and proposed legislation, to sickness insurance and to other matters which may be submitted by the Board of Trustees."

* * *

The American Medical Association Report Should Be Read by Every California Medical Association Member.—The report of the Reference Committee was given by its chairman, Dr. Harry H. Wilson of Los Angeles, and is a pronouncement worthy of the careful thought and consideration of every member of the California Medical Association. Each of our representatives who went to the Chicago meeting put aside his personal professional work for more than a week in order, as a delegate from the California Medical Association, to render his bit of service to his fellows. Every other member of the California Medical Association should also do his bit by at least acquainting himself with the conclusions finally arrived at by our national body.

* * *

Special Session of the California Medical Association House of Delegates.†—The House of Delegates of our own State Association will meet

* Doctor Yoell who, on the Committee of Five, was most active in advocacy of the plan incorporated in the Ingber resolution, had declined membership on the Committee of Six, expressing himself, however, as being willing to serve on the advisory committee.

*Excerpts from the California survey, as given in the Preliminary Report, appear on page 160; resolutions of the House of Delegates of the American Medical Association on page 207; and minutes and resolutions of the special session of the House of Delegates of the California Medical Association, on pages 187 and 194.

† The call of the special session of the House of Delegates of the California Medical Association was printed on page 126 of the February issue. As previously stated, the March issue of California and Western Medicine is brought off the press two weeks later than its regular mailing date to permit inclusion of the minutes of the special session of the House of Delegates of the California Medical Association.

at Los Angeles in special session on Saturday, March 2,

(*a*) to receive and consider the report of the Committee of Five, and to take such action thereon, and to formulate such principles and policies in regard to health insurance, medical services and medical care as the judgment and wisdom of the delegates may determine to be for the best interests of the public and the members of the Association;

(*b*) to transact such other business of the Association as may be transmitted to the House of Delegates by the Council of the Association.

If possible, the action taken on behalf of the California Medical Association by its own House of Delegates will also be printed in this issue.‡

YOSEMITE ANNUAL SESSION

This Year's Annual Session from May 13 to 16. —The attention of members is called to the fact that in about two short months the annual session, to be held May 13 to 16 at Yosemite National Park, will be upon us.

Because of the excellent scientific and other programs which are promised, and of the opportunity to see this wonderland of the national park service in a special setting of cordial, professional fellowship, every member of the California Medical Association who can conveniently arrange his work is urged to attend this year's meetings.

* * *

Interchange of Thought on Medical Problems Important.—The exchange of viewpoints on some of the important economic and other problems which confront organized and scientific medicine is today much to be desired, in fact more than ever before. Keep in mind that the California Medical Association needs you and that you need the California Medical Association. At Yosemite these beneficial contacts can be most happily realized and appreciated. Elsewhere in this issue of California and Western Medicine (on page 212) is a list of the hotels. Whether you go into the Yosemite Park by train and stage, or by automobile, it is advisable to make hotel reservations in ample time. Such coöperation will aid the hotel management in giving adequate service to all who attend. The complete scientific and other programs will be printed in next month's issue.

PROPOSED PUBLIC HEALTH LEGISLATION

List of Proposed Public Health Laws.—On page 229 of California and Western Medicine is printed a list of almost two hundred bills having to do, directly or indirectly, with public health laws of California, thirty-five having been submitted by State Senators and about one hundred and fifty by State Assemblymen. Brief comments indicate the nature of the proposed statutes. The perusal of the list is commended to all members of the California Medical Association because, in that way, the profession will better be able to appreciate the heavy labors in store for the Committee on Public Policy and Legislation (of which Dr. Junius B. Harris of Sacramento is chairman) and other officers.

* * *

Proposed Legislation Is of Importance to All Physicians. — Any member who feels that such perusal might prove a waste of time may be reminded that some of the proposed laws have to do with compulsory health insurance, and that in their amended and final form (if they should go on to enactment) they would very considerably change the scientific and economic phases of medical practice. By now every alert member of the medical profession knows that in the national congress and also the legislatures of some forty states which will be in session this year, not one, but many measures are sure to be introduced which, should they become laws, would bring about radical departures from the established form of medical practice. However, at this time it is not our purpose to discuss the important subject of health (sickness) insurance in these columns, lest the editor's personal views be misunderstood and accepted as official statements from the Association or its officers. Until the Committee of Five (appointed through action of the House of Delegates at last year's Riverside annual session) brings in its report, and until the House of Delegates of the California Medical Association acts thereon, these editorial columns will call attention only to reports printed in this or other journals which may aid members of the Association to secure as broad a viewpoint as possible of different phases of the much-complicated health insurance problem.

* * *

The Hoffman Articles. — In this connection, reference may be made to the series of contributed articles from the pen of Frederick L. Hoffman, which began in April, 1934, and now are brought to a close in the current issue.* We understand that some criticism has been made concerning these papers, but to date the editor has received no communications in which specific attention is called to any errors or misstatements by Doctor Hoffman. Had such been received they would have been given publicity in regular manner in the Correspondence column. It may be proper, therefore, to state that the policy of California and Western Medicine, as laid down by the Council, regarding contributed articles, has been posted for years at the editorial masthead and is expressed in the following language:

Responsibility for Statements and Conclusions in Original Articles. — Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

‡ Editor's Note.—The March issue of California and Western Medicine is mailed later than usual in order to print proceedings of the special session of the House of Delegates, held at Los Angeles on March 2 and 3. See page 194 for these reports.

*At the 230th meeting of the Council it was voted to complete the series of Hoffman articles on phases of sickness insurance (Item 11 on page 213).

How Copies of Proposed Laws May Be Obtained.—Every one of the almost two hundred proposed public health laws could be made the subject of special editorial comment, but lack of space prevents. Members desiring copies of particular bills can usually obtain them by addressing the State Printer, the Hon. Harry Hammond, State Printing Office, Sacramento. For the information of members, however, who are all supposed to be interested, reference will be made to a few of the bills offered for enactment.

* * *

Qualifying Certificate Act.—This measure was introduced on January 26 as Assembly Bill 1552, by Assemblyman H. Dewey Anderson of Santa Clara County and James J. Boyle of Los Angeles County. Its general form was approved by the California Medical Association Council, and its provisions are practically the same as those previously outlined in this column. In its course through the committees, suggestions may be made for desirable amendments.

* * *

Clinic Law.—This is Assembly Bill 1009, introduced by Assemblyman Roy J. Nielsen of Sacramento County, and recalls a draft of the law which, when first introduced two years ago, provoked a very severe fight in the legislature. The California State Board of Health was deputized to carry out the Act; but owing to some obscure provisions an opinion was sought from the State Attorney-General. One of his rulings made it impossible for the State Board of Health to do little more than compile a list of existing dispensaries in the State. In the opinion he gave, the Attorney-General ruled that no clinic should be obliged to pay more than $5 annually; which would result in assessments so low that when totaled they could amount to only about $600 per year, or a sum quite inadequate to cover the costs of worthwhile clinic inspection work. In the amended draft the annual fee is placed at $20, making possible the creation of a fund with which some real work may be done in the future.

* * *

Bureau of Tuberculosis.—In the August, 1934, issue of California and Western Medicine, on page 118, Dr. W. P. Shepard referred to the California Tuberculosis Commission's report of 1915, in which was advocated a Bureau of Tuberculosis, together with a revolving State fund, to compensate counties which maintained satisfactory facilities for the care of the tuberculous sick. During the last twenty years, California's excellent record in tuberculosis work has led other states to adopt somewhat similar laws. In Assembly Bill 1928, introduced by Assemblyman Gene Flint of Los Angeles County, an amendment has been introduced which *deletes* from the law of 1915 the following vital language:

"provided, that the city, county, city and county, or group of counties shall not become entitled to receive such State aid unless the tuberculosis ward or hospital conforms to the regulations of and is approved by the State Bureau of Tuberculosis."

If this proposed amendment should become a law, it would throw the tuberculosis work of the State and counties into considerable disorder, and would lay the foundation for a "racket" whereby the yearly demands upon the State treasury could run into many thousands of dollars more than at any time in the last two decades; with a real deterioration, at the same time, in the service given to the tuberculous sick. It would be interesting to know who were the motivating forces back of this proposed and astonishing change in an already excellent and perfectly satisfactory law!*

* * *

"Noxious Odors" Law.—In Assembly Bill 2154, Assemblyman Harry B. Riley of Long Beach, Los Angeles County, proposes:

"An Act to provide for the establishment and maintenance of a bureau in the State Board of Public Health for the suppression of noxious odors, prescribing its powers and duties, and making an appropriation to carry out the provisions hereof."

It is to be assumed that this measure was introduced as a means of alleviating some of the unwholesome odors from the Signal Hill oil district; but it would place a heavy, and probably an impossible burden, upon the State Board of Health, which with its lessened budget of late has had to do its other and really important work upon little more than a skeleton basis.

* * *

Physicians and Hospital Records.—Assembly Bill 2158, introduced by Assemblyman John G. Clark (an attorney by profession), also having a home address in Long Beach, Los Angeles County, is a short bill, but one so astounding in its provisions that it is here quoted in full. In view of the many court decisions on the inviolability of confidential relationships, not only for the medical but for the legal profession, it is difficult to understand how such a measure as the following could even have been seriously proposed:

"An Act making it unlawful for hospitals, clinics, sanitariums, physicians, surgeons, or other persons to refuse inspection of records by attorneys.

"The people of the State of California do enact as follows:

"Section 1. It shall be unlawful for any hospital, clinic, sanitarium, physician, surgeon, or other person or institution having in his or its possession records concerning the condition of health of any person made while said person was in the care of such person or institution, to fail or refuse to exhibit said records to any duly qualified and practicing attorney at law, desig-

* Editor's Note.—Under the supervision of the Bureau of Tuberculosis, based on standards laid down by the California State Board of Health, the allocation of State funds for tuberculosis work runs into massive figures. Without such standardization and supervision and cross-check on claims of counties for reimbursement, the State's expenditures would be tremendously increased. The following figures should be of interest because they show the appropriations for subsidies, and the allotments made for the support of the Bureau of Tuberculosis, covering the last six years:

Fiscal Years	Allotments for Bureau Support	Appropriations for County Subsidies
Eighty-first and eighty-second (Ending June 30, 1931)	$47,400.00	$819,132.52
Eighty-third and eighty-fourth (Ending June 30, 1933)	44,040.00	1,043,155.52
Eighty-fifth and eighty-sixth (Ending June 30, 1935)	18,040.00	975,000.00

nated by said person in writing, and to allow copies of said records to be made, provided said inspection shall be made during reasonable business hours, and provided further that at the time of said inspection there shall be either pending or contemplated, litigation in which said records will, in the opinion of said attorney, be helpful to the cause of his client.

"Sec. 2. Violation of this section shall constitute a misdemeanor."

* * *

Nursing Survey.—Senate Bill 417, introduced by Senator Thomas McCormack of Solano County, is

"An Act authorizing a nursing survey to be made by the University of California, defining the powers and duties of the State Director of Finance in relation thereto, and making an appropriation therefor."

The measure would authorize the expenditure of not more than $15,000 from the moneys that have been accumulating through license fees in the Nurses Registration Fund

". . . to defray the expenses of making a survey of nursing conditions in the State of California, including the preparation and calculation of all data and facts concerning the education, training and employment of nurses, and the administration of the teaching of students preparing for nursing and public health service."

If the various nursing organizations in the State are willing that such a survey be made, it would seem that no objection should be raised.

* * *

The Heavy Responsibility of the Council and the Committee on Public Policy and Legislation.—From what has been here written concerning a few of the many public health measures (on every one of which the Council of the California Medical Association must go on record as being either in favor of, against, or simply neutral) it becomes evident that much work will yet come before the profession up to the time the present (fifty-first) California Legislature adjourns (probably some time in May).

Meanwhile the interests of organized and scientific medicine will be under the constant supervision of the California Medical Association Committee on Public Policy and Legislation, the names of whose members may be found in the directory on page 2 of each issue of this official journal. If that committee, therefore, should call on members of the Association for aid, it is to be hoped that they will whole-heartedly give of their generous support, such as the committee's labors and important responsibilities at all times warrant.

SERA AND MEDICAL RELIEF

Los Angeles County Medical Association Announces a Working Plan with the SERA.—On page 227 of this issue of CALIFORNIA AND WESTERN MEDICINE is reprinted the announcement, recently sent to its members by the Los Angeles County Medical Association, concerning the arrangements which have been made with the officials of the State Emergency Relief Administration (SERA) to cover the medical care of the unemployed.

It is most gratifying to learn that in a large metropolitan center of California it was finally possible to come to some kind of working agreement with the federal and state authorities who had in hand the relief of the unemployed. In one or two of the California counties having lesser populations, arrangements to compensate physicians for medical relief work rendered to the unemployed have been in operation for some months. In Los Angeles County, on several occasions in the past, the Los Angeles County Medical Association was prepared to put into operation plans that had been submitted, and that would have been satisfactory, but each time precipitate and unforeseen changes in the ever-shifting lay personnel of the federal and state emergency relief administrations brought the conferences and agreements to naught.

* * *

Medical Relief Is a Basic Need.—In some states of the Union more or less satisfactory county arrangements have been in operation for a year or more. No legitimate reason can be brought forward against adding, to the other basic needs of food, clothing and shelter, that of medical relief to safeguard the health and lives of unemployed citizens. Nor can any sound argument be advanced or reasons be given why members of the medical profession should not be paid moderate fees for services so rendered, just as are their lay fellow citizens from whom the federal, state, and local governments purchase shelter, food and clothing for such unemployed persons.

* * *

Other Component County Societies Should Do Likewise.—It is hoped that this coöperative effort on the part of a component county society of the California Medical Association, to offer its services and to act as the intermediate medical agent through which the services of all licensed physicians and surgeons who wish to participate in the relief work may be placed at the disposal of the local relief administration, will lead other county units to also work for similar agreements. As the plan stands, it is not limited to members of the county society, but is open to all licensed physicians and surgeons of reputable character.

The officers of the Los Angeles County Medical Association are to be congratulated on having brought to reality this agreement by means of which governmental and local agencies work hand in hand in medical relief for the unemployed. One additional thought: If the Los Angeles County Medical Association was able to successfully negotiate the difficulties involved in bringing its working agreement to a happy consummation, why should not all other component county medical societies in California initiate steps to bring about the adoption of similar agreements for their respective members?

* * *

Plan Keeps Medical Matters Under Control of the Medical Profession.—One of the strong advantages of the Los Angeles plan is that it places the medical supervision and detailed professional work entirely in the hands of physicians, the governmental agencies looking to the county medical society to safeguard in proper manner the

joint interests of the State, the unemployed, and the medical profession. Also, it is an admirable way of trying out and learning to what extent the medical profession can give medical relief to low- or no-bracket income citizens, without the intervention of lay bureaucrats to tell physicians how they must perform their medical work. Whatever disciplinary supervision may be needed on matters medical, from the standpoints of both scientific and economic medicine, will be handled, not by lay supervisors, but by subcommittees of medical men appointed by the Los Angeles County Medical Association.

EDITORIAL COMMENT*

THYROID THERAPY AND SCARS

The occurrence of hypertrophied scars and keloidal growths of the skin is of interest in all branches of medicine. The causation has been as obscure as the factors associated with the etiology of cancer.

Necessarily some trauma to the skin forms the background for the scar. The character of the resultant healing is a matter somewhat of conjecture. Previous perfect healing is of uncertain favorable prognostic value. A keloidal personal history, however, is markedly unfavorable, and a familial keloidal history is likely to prove an hereditary tendency. Pathologic examination of hypertrophied scar and keloidal tissue has disclosed little or no tangible difference from ordinary scar tissue.

Healing, *per se*, is of course influenced by the causative trauma, inflammation, infection, tension, suture material, antiseptics, pressure, etc. However, none of these have been found uniformly as the cause of permanent hypertrophied scar and keloidal involvement.

In June, 1933, in a paper read before the American Medical Association, the writer called attention to the interesting returns of a large number of minus basal metabolic readings in patients with hypertrophied scars and keloids. The fact that these patients improve with thyroid therapy has been a consolation to the surgeon. It is to be understood, however, that we have not reached Ehrlich's dream of a single dose of medicine correcting a condition at once, or anything like it.

A large percentage of our reconstructive plastic surgery cases with hypertrophied scars and keloids have benefited materially with one or two grains of thyroid substance, *per orem*, daily. Improvement is noticed within thirty to sixty days, but the medication may have to be carried on for an indefinite period. It is to be noted, in this type of patients who scar badly, that the glandular therapy also causes a marked improvement in the general physical and mental condition.

The basal metabolic rate offers perhaps the only easy method of determining functional glandular measurement in a patient, and clinical symptoms and observations evaluate the glandular status in others.

The consensus of medical opinion seems to be that the ductless glands are more or less dependent on one another. In calling attention to thyroid insufficiency as a factor in poor skin healing, we must think, then, of the possibility of poor healing in all subglandular cases. Skin healing may also offer a picture of internal healing following trauma. The earlier this type of patient is recognized before surgery and treatment are instituted, the better our results will be.

6777 Hollywood Boulevard.

HOWARD L. UPDEGRAFF,
Hollywood.

TREATMENT OF MALIGNANT MELANOMAS

When one thinks of malignant melanomas, he is apt to look upon the victim as being doomed. Indeed, the five-year end results from a surgical standpoint are so depressing that such an attitude is probably justifiable. Thus, Broders and McCarty reported seventy cases in 1916, of which patients only 5.2 per cent lived for from four to eight years after surgical excision. Bloodgood reported 200 cases treated by surgery and the cautery, and only one lived five years. McCain saw six cases, and two lived five years after radiation alone. In a recent issue of *Acta Radiologica*,† Scharngel of New York City, who was studying at Radium Hammet in Stockholm, reports on eighty-one patients seen at that institution from January, 1921, to July, 1930. Here a technique of combined electrosurgery and radiation, either by radium or x-ray, has been evolved, which has resulted in a remarkably high percentage of five-year cures. Of the eighty-one patients seen, only seventy were actually treated; but by the technique they had evolved, 38.7 per cent were living over five years. Thirty-six of these patients had metastasis—nine living for three years, and four for five years. In view of these results, an extremely pessimistic viewpoint is not justifiable. Melanomas are very malignant, but by a combined electrosurgical and radiological technique many patients have almost a 40 per cent chance of a five-year survival.

These figures are very impressive, but represent a method of treatment which must be carried out with precision to accomplish such results. The electrosurgery is thorough, and the radiation therapy is pushed to the limit of tissue tolerance. The possession and use of a surgical diathermy unit and a fifty-milligram tube of radium in this condition is not enough; it requires experience in management and the use of massive amounts of radium up to two or three grams to accomplish the best results and to insure complete eradication and permanency of cure.

1407 South Hope Street.

ORVILLE N. MELAND,
Los Angeles.

* This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

† Treatment of malignant melanomas of the skin and vulva. Acta Radiologica, Vol. XIV, No. 81, p. 473.

MINUTES—SPECIAL SESSION OF HOUSE OF DELEGATES OF CALIFORNIA MEDICAL ASSOCIATION

AT LOS ANGELES ON MARCH 2, 3, 1935

OFFICIAL MINUTES, SPECIAL MEETING, HOUSE OF DELEGATES, CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Meeting of the First Day

Saturday, March 2, 1935, 1 o'clock a. m.

In response to the call issued by the Council, the House of Delegates of the California Medical Association convened in special session in the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles, California, on Saturday, March 2, 1935, at 1 p. m.

The meeting was called to order by Speaker Edward M. Pallette.

The Speaker: The meeting will please come to order. The first order of business is the report of the Credentials Committee, Dr. Eric Larson, chairman.

The Speaker: You can report on the list as submitted.

Doctor Larson: Yes, we can approve the list that has been submitted and the delegates that have badges.

The Speaker: The secretary will call the roll. At this time, I would like to introduce to this House of Delegates Dr. Frederick C. Warnshuis, our new secretary. (Thereupon the secretary called the roll.)

REFERENCE COMMITTEES NOS. 1 AND 2

The Speaker: The secretary reports a quorum present. The Speaker at this time would like to announce an additional committee, a Reference Committee. We had appointed one Reference Committee, consisting of Dr. Philip K. Gilman of San Francisco as chairman, F. N. Scatena of Sacramento and Lowell S. Goin of Los Angeles. The Council has found that there will be so much work for this committee to do that we are going to limit their work to a consideration of the recommendations on the report of the Committee of Five, so that there will be an additional committee to consider other resolutions. This will be Reference Committee No. 2, Dr. Carl R. Howson of Los Angeles, chairman. L. R. Chandler of San Francisco and George H. Kress. The Speaker has appointed Dr. E. V. Askey as sergeant at arms.

EXECUTIVE SESSION

Doctor Clarke: I move that this House of Delegates go into executive session, and that only those who are accredited delegates and members of the California Medical Association be permitted to participate in this executive session.

The Speaker: Is there a second to this motion?

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that we go into executive session, and that only members of the House of Delegates and members of the California Medical Association be admitted. Those in favor say aye. Those opposed say no. It is carried. The secretary will now read the call for the special meeting.

(Secretary reads call for special meeting.)

The Speaker: The House is now duly constituted and open for business under the call. The next order of business is the report of Doctor Molony.

* * *

Doctor Molony: Mr. Speaker, may we have the Supplement to the Preliminary Report submitted to the California Medical Association Committee of Five for the study of medical care?

I would like to have that report distributed to the delegates.

Mr. Speaker, and members of the House of Delegates of the California Medical Association: The Committee of Five appointed upon the authority of the House of Delegates at the meeting of the California Medical Association at Riverside in 1934, respectfully submits the following report.

REPORT OF COMMITTEE OF FIVE

I

March, 1, 1935.

To the House of Delegates:

(*a*) The Committee of Five, appointed under the authority of the House of Delegates at the meeting of the California Medical Association at Riverside in 1934, respectfully submit this report. The following resolution was adopted at the above-named meeting:

Resolved, That a committee be, and hereby is constituted, consisting of two members of the Council to be appointed by the chairman of the Council, and three members of the House of Delegates to be appointed by the Speaker of the House, whose duty shall be the consideration of health insurance.

Resolved, That this committee shall be instructed to conduct an adequate study and survey of the problem as it applies to California and to formulate a plan for the administration of health insurance and to prepare a bill for suitable legislation which may be available for presentation in the 1935 session of the California State Legislature.

Resolved, That the Council be, and is hereby instructed to appropriate funds sufficient to employ adequate and competent technical and legal assistance and advice for the purpose of this committee.

(*b*) The members of the Committee of Five are Doctors Robert A. Peers, Alson Kilgore, Rodney Yoell, Harry H. Wilson, and William R. Molony, Sr.

(*c*) The organization meeting was held in Los Angeles on June 2, 1934. At the meeting it was voted that the committee operate under the name of the California Medical Association Special Committee for the Study of Medical Care. Dr. William R. Molony, Sr., was elected chairman, and Dr. Harry H. Wilson was elected secretary. After many conferences the survey was organized, with Paul A. Dodd, Ph. D., as director of the survey. He is assistant professor of economics, University of California at Los Angeles, and Gordon S. Watkins, Ph. D., as supervising director, consulting economist, professor of economics, University of California at Los Angeles.

(*d*) An advisory council, consisting of the following, were named: John B. Canning, Ph. D., professor of economics, Stanford University; Arthur G. Coons, Ph. D., dean of men and associate professor economics, Occidental College; Rockwell D. Hunt, Ph. D., dean of the Graduate School, University of Southern California; the Reverend James J. Lyons, S. J., president of the University of Santa Clara; Samuel C. May, Ph. D., professor of political science, director of the Bureau of Public Administration, University of California.

(*e*) The director started the work of the organization of the survey on August 1, 1934. The first meeting of the committee was held on August 13, 1934, at which time the outline of the study was approved.

The possibility of securing aid for field and tabulation work from the Government through the SERA having been discussed, the first application for aid

from this source was made on August 25. It was only after many conferences with State and Federal authorities by Doctors Dodd and Wilson that the application was finally approved. The field work started in Orange County on October 3 and continued in Riverside County a week later. On the basis of a preliminary report to Washington of our organization set-up and our findings through the field work in Orange and Riverside counties, the Federal Government approved the project and authorized an appropriation for the work.

In order that the information called for in the survey might be representative of the whole State and of the different industries in the various parts thereof, the field work was done in twenty-six counties, representing the urban, suburban, farming distribution of the population, so that the field work, state-wide in extent, which began on October 3 in Orange County and extended from Humboldt County on the north to San Diego County on the south, was finally completed on January 16, 1935. The objective of the Survey was to ascertain from all available sources the information as to experience of the people of California as to sickness, together with all of the agencies concerned in the medical and hospital care. A questionnaire was sent to every physician and surgeon, osteopath, and dentist in the State. Considerable difficulty was experienced in obtaining the prompt coöperation from these groups, and repeated requests were necessary in order to obtain even a fair return.

3,600 complete returns were received from the physicians.

2,000 complete returns were received from the dentists.

800 complete returns were received from the osteopaths.

230 complete returns were received from the hospitals.

150 complete returns were received from the clinics.

24,000 completed questionnaires or schedules were obtained from families.

21,000 by the field worker, and 3,000 by mail from sparsely settled districts.

Since the completion of the field work, the tabulation of the results has been under way and, while good progress has been made in this regard, the director, Doctor Dodd, states that this phase of the work cannot be completed before May or June of this year. During December, 1934, January and February, 1935, the committee has had many meetings, contacting from time to time the Advisory Council, the Research staff, the Council of the California Medical Association, the Interim Committee of the State Senate, and other interested agencies.

By reason of the magnitude of the undertaking, the time-consuming task of proper tabulation of the results of the Survey, and the lack of time for a thorough digest of the information at hand, has made it very difficult for the Advisory Council, the Research staff, and the committee to make a comprehensive and deliberate study for the purpose of submitting a report which will adequately convey the real situation in California.

(*f*) When it was found necessary that a governmental agency must sponsor any project before Federal funds could be made available, the California State Department of Public Health gave their unqualified sponsorship to the project. The committee wishes to express their appreciation of this action.

(*g*) The Committee of Five desires to express its cordial appreciation of the spirit of coöperation in its work accorded by the Senate Interim Committee.

II

(*a*) The committee has available as a part of this report a financial statement including an outline of the scope of work as accomplished and contemplated for final presentation when desired.

CALIFORNIA MEDICAL-ECONOMIC SURVEY

Financial Report

Expenditures—August 1, 1934 to March 1, 1935:			
Salaries—			
Full time staff—Administrative and office	$7,042.76		
Statisticians	1,697.66		
Field supervisors and visitors	3,538.57		
Professional coders, editors and machine operators	1,059.10		
Part-time office help	695.43	$14,033.52	
District office expenses		319.95	
Furniture rental		445.00	
Machine rental		489.56	
Office rental		373.51	
Postage		2,382.04	
Printing		2,090.70	
Reports, books, etc.		79.40	
Office supplies		1,187.23	
Telephone and telegraph		594.19	
Traveling expenses—			
Meals	477.10		
Hotels	512.50		
Transportation (fare)	907.60		
Postage	38.37		
Telephone and telegraph	85.40		
Tips	49.45		
Supplies	41.43		
Miscellaneous	203.42		
Car expense	704.84	3,020.11	
Maps and field supplies		167.89	
Contingent expenses—			
(Insurance, freight, bonds, etc.)		232.17	
Total expenditure by California Medical Association			$25,415.36
SERA Government Appropriation—			
Original	$41,505.20		
Supplement	13,920.22		
*Total SERA Appropriation			55.425.42
			$80,840.78
Total receipts from California Medical Association	$26,000.00		
Total expenditures—August 1, 1934 to March 1, 1935	25,415.36		
Cash balance		584.64	
Balance in bank, March 1, 1935		334.64	
Petty cash fund on hand		250.00	
Total cash balance		$ 584.64	

*Note: Government appropriations include all grants necessary to finish survey work. About $4,000 still remains to be used from these government grants. These appropriations were secured upon official request by the California State Board of Health.

(*b* and *c*) The preliminary report of the staff to the Committee of Five has been submitted to each member of the House of Delegates together with the supplementary report, which is now available. The correlation of the statistical data as gathered will be continued and when properly digested will be made available in the final report of the committee and the Survey staff on completion of the study.

(Exhibit B—Preliminary Report of survey.)

(Exhibit C—Supplementary Report of survey staff.)

CONCLUSIONS

In order that the medical profession may continue to serve the people of the State in the prevention of disease, the maintenance of health and the curative care of illness, in a manner that will meet the apparent economic factors, and at the same time protect public welfare by safeguarding to the medical profession the functions of control of professional standards, the continued advancement of educational requirements and at the same time not destroy the initiative which is vital to the highest type of medical service,

The committee recommends that the House of Delegates adopt as its plan the furnishing of health service on a voluntary basis to the people of California on the plan and by the mechanism herewith outlined, rather than approve of the establishment of compulsory health insurance.

The proposal which has been adopted by the committee for recommendation to the House of Delegates is one primarily prepared for the committee by a subcommittee of one, and will be presented to the House of Delegates by this subcommittee.

In accordance with the instructions of the House of Delegates in constituting the Committee of Five, a health insurance bill was submitted to the House of Delegates. The majority of the committee believe that compulsion as embodied in the compulsory health insurance bill is incompatible with adequate medical care to the greatest number of people in the State of California; therefore, though fulfilling the instructions that a bill be drafted which may be available, the committee recommends that it be not adopted as representing the policy of the California Medical Association.

The bill was primarily drawn by a subcommittee of one, and will be presented to the House of Delegates as a part of a minority report by this committee.

Respectfully submitted,
William R. Molony, *Chairman*
Alson Kilgore
Robert Peers
Harry H. Wilson
Minority: Rodney Yoell.

* * *

Doctor Molony: You have had sent to you the Preliminary Report, the large bound volume, on January 16, or some time after that, and today you have the Supplementary Report of the work completed to date. This is respectfully submitted and signed William R. Molony, Alson Kilgore, Robert Peers, Harry H. Wilson. I think it would be advisable at this time for Doctor Kilgore to present to the House a Committee of One's report as far as voluntary insurance is concerned.

The Speaker: Doctor Kilgore.

Doctor Kilgore: Mr. Speaker and members of the House: It is my understanding that it is not in order at this time to introduce argument. I shall confine myself, therefore, to presenting the report of the Committee of One to the Committee of Five, which has been made a part of the report of the Committee of Five, with instructions and explanatory comments. This has been presented through the mails to all the delegates in the form of a mimeographed set of sheets headed here "Proposed Declaration of Purpose by the California Medical Association." Mr. Speaker, does the House desire that I shall read this all. Each and every one here has a copy.

(Report presented.)

REPORT AND RESOLUTION OF DOCTOR KILGORE ON A PLAN OF VOLUNTARY INSURANCE

To the House of Delegates:

This report as submitted consists of: (1) a preamble; (2) an outline of a plan; (3) a resolution embodying the principles of a voluntary health insurance plan to be considered by the California Medical Association.

Your committee recommends that the report be amended to delete x-ray, laboratory and anesthesia from the hospital services.

If the House of Delegates adopt the principles contained in this report as amended, the House of Delegates should not commit itself to the detached provisions of the specific plan (Part 2 of the report), but should have the Council or other delegated body free to modify details after conference with all other interests involved, and to adopt and support any plan of voluntary service consistent with said principles.

PREAMBLE

The medical profession of California recognizes that inevitably increasing costs of good medical care coupled with an increasing percentage of population in low income groups has presented a growing social problem. We have earnestly sought methods of meeting this problem and have been forced to conclude that it can be met only by spreading the costs of the illnesses of the few among the many subject to the risk, *i. e.,* by health insurance.

The California Medical Association further recognizes that not only should health insurance be made available but that, for the final solution of the social problem involved, the system may very well have to be a compulsory one, for the very obvious reason that under a strictly voluntary system some individuals who most need protection will not accept and pay for it.

The profession clearly recognizes grave dangers and faults of health insurance, some inherent in the system itself, others avoidable or at least minimizable by careful planning on a basis of practical experience. Among these dangers are:

(1) Interference by an administrative machinery between patients and their physicians.

(2) Development of political control and a bureaucracy of supervision, sapping funds which should be used for the care of the sick and degrading medicine and medical service.

(3) Diversion of time and energy to the red tape of "paper work" and to the prevention of malingering—time and energy which should be spent only in medical service to the sick.

Recognizing these and many other dangers, the California Medical Association appreciates its obligation to the people of the State to plan and conduct this branch of health service to the community in such form and manner as to preserve (in so far as is humanly possible) the highest standards of service of physicians to the community. We must see to it that health insurance is organized and operated so that its evils will be minimized and its advantages best utilized for the people.

The California Medical Association is cognizant not only of the above dangers but also of the difficulty and complexity of the problems of organization and administration of a system suitable for America. The people of California would, and should not, be satisfied with health insurance furnishing, as in the British system, only office and home treatment, leaving them to the mercy of charity when special services and hospital care are required. The experience of foreign systems will not furnish solutions to all the intricate and complex relationships of consulting services in all the specialties, to say nothing of hospital care.

At the present time the California Medical Association believes that no one can be sure of the best answers to many of the problems involved and that no amount of theoretical debate will suffice. We believe that these problems should be worked out in the school of practical experience before the provisions are incorporated into law, because any initial legislative error might well prove costly and disastrous.

We believe that with experience first in the actual practical operation of health insurance on a voluntary basis, we shall arrive sooner at a more satisfactory compulsory system than if attempt is made to write the final law today.

The California Medical Association, therefore, proposes to set up, on its own responsibility with the coöperation of hospitals and other interested groups, and offer to the people of California a health insurance service and to this end has adopted the following resolution of instructions to its Council.

RESOLUTION

Whereas, The California Medical Association recognizes that the costs of illness and the attendant medical, dental and hospital care are now unevenly distributed and constitute a grave financial hazard to those of moderate and low incomes; and

Whereas, The California Medical Association also recognizes that, on account of this very financial haz-

ard, many individuals faced with serious illness must often choose between charity and inadequate care; and

WHEREAS, After nine months' study and the expenditure of a large sum of money with the coöperation and financial support of the Federal and State governments, it has become apparent that the only practical solution to this problem at present available is the utilization of the insurance principle; and

WHEREAS, The California Medical Association believes that arrangements should be made whereby those of moderate and low incomes may provide against these financial hazards by the utilization of this principle of insurance; and

WHEREAS, The California Medical Association believes that, since it constitutes the organized medical profession of this State, an effort to solve the problem of providing ways and means for the above purposes constitutes a part of its obligation to the people of California; now, therefore, be it

Resolved,

(1) That the California Medical Association establish an organization for the specific purpose of providing means whereby the costs of care in sickness and injury for those of moderate and low incomes may be met by the method of periodic payments in advance.

(2) That this organization shall contemplate providing for meeting costs of both professional services and hospital care.

(3) That the Council be and is hereby instructed to perfect a plan of organization, scope of service and rules of operation for the purposes herein set forth, and that the Council be and is hereby instructed to set it up and cause it to be put into operation as soon, and for such scope of service, as may be found lawful and practical, specifically having in mind that, whatever initial scope of service and operation may be determined upon, it is the eventual purpose of the California Medical Association to make the use of this contemplated organization available to all citizens of the State (within certain income limits) for provision against costs of both complete professional service (including specialists' services, surgical operation, dental care as it relates to the eradication of infection) and hospital care.

(4) That, in the plan of organization and rules of operation, the following provisions shall be adhered to:

(*a*) Both financial and administrative responsibility shall be assumed by the organized medical profession through such organization.

(*b*) Free choice of physician, dentist and hospital by patient shall be maintained.

(*c*) Practice under the plan shall be open to reputable physicians and dentists, regardless of membership in the California Medical Association or the State Dental associations.

(*d*) In so far as is humanly possible in the conduct of any plan of collective financial action, the traditional private patient-private physician relationship shall be maintained.

(*e*) Compensation to physicians shall be on a basis of services rendered.

(*f*) Compensation to physicians shall be paid only for services personally rendered (except that special permission may be given physicians to have bona fide assistants associated with them in furnishing services).

(*g*) Arrangements for provision of dental care contemplated shall be made by and with the State Dental Associations.

(*h*) The plan shall be operated without profit to anyone.

(5) That the Council be and is hereby instructed to appropriate such sums of money as may be necessary to the accomplishment of the purposes of this resolution, and in addition to assess (or levy) such amount of per capita contribution by physicians and dentists desiring to care for patients under the arrangements contemplated as may be deemed necessary for organization and institution of operations.

(6) That the Council be and is hereby instructed to take steps toward securing any and/or such legal enactments as may be necessary for the lawful carrying out of the purposes of this resolution.

Respectfully submitted,

ALSON KILGORE.

* * *

The Speaker: These reports will be referred to Reference Committee No. 1. Any other report from the Committee of Five? Have you any report, Doctor Yoell?

Doctor Yoell: Mr. Chairman and fellow members of the House of Delegates of the California Medical Association. This is a minority report of the Committee of Five to the Council of the California Medical Association, pursuant to the instructions passed by the House of Delegates at its last meeting.

(Report read.)

REPORT OF DOCTOR YOELL ON A PLAN OF COMPULSORY SICKNESS INSURANCE

To the House of Delegates:

Your committee has carefully and at great length considered the problem under discussion. We are of the opinion that the present system of medical practice is not satisfactory inasmuch as the people are not receiving nor can they receive proper medical care, as it now functions.

This situation is directly traceable to the undoubted inability of a large majority of the population to finance on an individual basis the essential cost of health service.

It seems logical, therefore, that the insurance principle be applied as a method of accomplishing by coöperation that which cannot be accomplished individually.

Our studies have shown that it is the almost universal experience in civilized countries which have tried the insurance principle that such application must be compulsory to be effective and we, therefore, recommend that the House of Delegates of the California Medical Association endorse the principle of compulsory health insurance and ask at this session of the legislature the enactment of such statutes as will carry it into operation.

We further consider and are of the opinion that only by this method will proper medical service be secured to the people, and only under this method can the medical profession survive in an independent rôle. It is not a question of voluntary insurance versus compulsory insurance; viewing the political scene we feel it is either insurance or some form of state medicine.

The following minority report of the Committee of Five is offered pursuant to your instructions. A plan is submitted for a system of compulsory health insurance and a bill is offered in support of the plan, which coördinates much legal and technical opinion. We suggest that the principles embraced in the plan and the bill be the basis of discussion with the Senate Interim Committee as representative of the opinion of organized medicine.

The final draft of the bill should contain a change in the composition of the commission. We endorse the proposal of the Advisory Committee that the commission should consist of five members, at least two of whom must be physicians; that three names for each commissionership should be submitted to the Governor by the Board of Regents of the University of California.

We suggest the elimination of certain recognized religious sects from the provisions of the act be considered.

We recommend the elimination of Section 33, page 26, and we recommend that no provision be made for contribution to the fund by the State.

Respectfully submitted,

RODNEY YOELL.

The Speaker: This report will be referred to the committee.

The next order of business is communications from the Council. Dr. T. H. Kelly.

COMMUNICATION FROM THE COUNCIL

Doctor Kelly: Mr. Speaker and members of the House of Delegates of the California Medical Association: The Council has called this House into session to consider the report of the special Committee of Five upon health insurance in California and such other matters as the Council may present to you. The report of the special committee you have heard from that committee. The Council desires to recommend to you that in the consideration of this report, you exercise the greatest care and thought. The Council believes that the House of Delegates should, in its action upon this report, decide the following questions:

1. Is the House in favor of the continuation of the present forms of medical practice in California?

2. Is the House in favor of a state-wide plan of voluntary medical and hospital insurance under the California Medical Association, and with the necessary enabling legislation to put it into effect?

3. Is the House in favor of a compulsory plan of health insurance, and if so, by legislative enactment or by initiative or constitutional amendment, and with what minimum provisions for medical administration of medical care?

4. If the House favors a voluntary plan, does it wish to formulate minimum standards of medical administration for a compulsory plan if the same should later come into being?

5. If the House favors compulsion, does it wish to authorize a voluntary plan to be put into effect by the California Medical Association in the event—a possible one—that compulsory health insurance fails to pass this legislature?

6. In the event that the House favors no change in the present forms of medical practice, is it in favor of the development and extension of hospital insurance plans fostered or controlled by the hospitals of California or by organized medicine?

The Council urges that these questions be answered, in order that it may have the authority to proceed according to the best interests of medicine and public health, regardless of what adverse action any determination of the policy by this House may meet in the immediate future.

Further, the Council urges that the House express itself upon the matter of county hospitals, the corporate practice of medicine and compensation for medical services rendered to those on relief. An attempt is being made to open up county hospitals to all residents regardless of their economic status, and this House, in the opinion of the Council, should go on record against the forces seeking to thus undermine the practice of medicine, and to introduce the worst form of State medicine that we could have. Corporations seeking to promote their ends are ever attempting to encroach farther into the practice of medicine, and the House should express itself upon this matter.

Finally, because of causes beyond the control of medicine in California, there has been a complete failure to develop any coördinated plan of medical care under the relief program in California. Medicine has been called on to care for all of those needing it, and little has been returned to those physicians giving, thus, of their time and skill. The House should urge both the Federal and State Emergency Relief Administrations to rapidly develop and put into operation a plan for medical care of those on relief in California, the plan to be worked out in conjunction with organized medicine, as stated by the rules and regulations No. 7 of the FERA.

The Council wishes to introduce, through its chairman, three resolutions that deal with those last three matters in the report, and they are introduced to put the question on the floor of the House. The House can do anything it wants with them. (See Reference Committee No. 2 report on resolutions presented.)

The Speaker: This communication and the other resolutions are referred to the Reference Committee No. 2, of which Doctor Howson is chairman. Other resolutions from the floor are now in order.

* * *

RESOLUTIONS FROM THE FLOOR

Doctor Ingber: In order to bring this matter properly before the House of Delegates, I have two resolutions here from the members of the San Francisco delegation.

The Speaker: Will you read them, please?

Doctor Ingber: Resolution No. 1. (Reads Resolution No. 1.) (See Reference Committee report.)

Resolution No. 2. (Reads Resolution No. 2.) (See Reference Committee report.)

The Speaker: These resolutions will be referred to Reference Committee No. 2. Are there any other resolutions?

Doctor Anderson: Mr. Speaker and House of Delegates: (See Reference Committee report.)

The Speaker: This resolution will be referred to Reference Committee No. 1. Any other resolutions?

Doctor Scott: (Reads resolution.) (See Reference Committee report.)

The Speaker: This resolution will also go to Reference Committee No. 1. Any other resolutions?

* * *

INFORMAL DISCUSSION

Now, this completes our docket for today. We can do one of several things.

According to the docket, we will adjourn until ten o'clock tomorrow morning. However, we can do this, if you so desire, we can have an evening session. These committees can adjourn at this time and get busy, and report back here probably at eight o'clock tonight, because the big part of this meeting is a discussion of these resolutions. We may get through by working all day tomorrow, and we may not. That depends on how much there is to be done, and so it has been suggested that an evening session might shorten the work tomorrow a great deal. Is it desired to have an evening session?

Doctor Wilson: It will be difficult for your Reference Committee to listen to discussions this afternoon and bring in any sort of constructive report by eight o'clock tonight. I don't think we can.

Doctor Molony: As a matter of fact, there is nothing before the House until the Reference Committees Nos. 1 and 2 have made their reports.

Doctor Ingber: May I make a motion to recess until tomorrow morning?

A Doctor: I second it.

The Speaker: The substitute motion is that we recess until tomorrow morning. Are there any remarks?

Doctor Crosby: I think that the Reference Committees ought to tell us whether they want to present anything to us tonight, and I think we ought not to put up recessing until tomorrow morning until we have an expression of opinion from the Reference Committees.

The Speaker: Doctor Gilman.

Doctor Gilman: It will be very difficult to have a complete report by eight o'clock tonight and have it in good shape to present to this society.

The Speaker: Doctor Howson.

Doctor Howson: I think Reference Committee No. 2 will probably be able to report by eight o'clock this evening.

The Speaker: We could take up No. 2 first. They are separate questions. If we could adjourn until this evening and have a report from Committee No. 2 and act upon it.

Doctor Kerr: I should like to ask if it would not be possible to have a discussion this afternoon. The committees would have today and all night if they chose to discuss the matters, and recess then until tomorrow morning.

The Speaker: Well, that might be enlightening to the committees. The committees are open for discussion at all times. Different members do go before the committees and discuss, and we could have this discussion open this afternoon, if you want to do it. The question now is that we can adjourn now until tomorrow morning, or when we adjourn, adjourn until tomorrow morning.

The Speaker: Those who are in favor of having an evening session will please stand. Now, those who are opposed to an evening session will please stand.

The Secretary: Mr. Speaker, 77 yes, 24 no.

The Speaker: The motion prevails. This motion would change the docket as given by the Council, and so it requires a two-thirds vote, and we will have the evening session. The motion is carried.

Doctor Wilson: Mr. Speaker, is it in order to make a suggestion? It would seem rather desirable, in view of the discussion, to have an open discussion tonight, and then let the committee retire tonight and have the resolutions submitted and the value of the discussions, and then make the reports in the morning.

Doctor Kress: They might bring in a report covering the consensus of the report.

The Speaker: You have already voted to have an evening session.

Doctor Kress: I move, Mr. Chairman, that we proceed with an informal discussion by this House of Delegates at this time.

Doctor Reiss: I second that.

The Speaker: It is moved by Doctor Kress, and seconded by Doctor Reiss, that we continue with an informal discussion. These committees, if they wish, can adjourn or stay here and get ideas. Are there any remarks? Those in favor, say aye. Opposed, no. Carried. The floor is now open to anyone who wishes to make a speech. I have an announcement to make. There will be a dinner at six o'clock, upstairs. All delegates are invited as guests of the Los Angeles County Medical Association.

A general discussion was then engaged in by Delegates Powell, Hale, Yoell, Crosby, Shepherd, Ullmann, Burns, and Ruddock.

* * *

Doctor Howson presented the following resolution:

WHEREAS, The organized medical profession of the State of California fully recognizes the difficulties and problems faced by those of its citizens having incomes below or near the subsistence level when confronted by the necessity of making provision for serious illnesses; and

WHEREAS, We not only view sympathetically any attempts to make it possible for such citizens and their families to meet such problems, and for several years we have been making intensive studies with a view to finding a solution which shall be a true solution and not merely an alternative resulting in more serious difficulties and in inferior medical services; and

WHEREAS, It is well known that the type of medical care received by the American people is, on the average, much superior to that of any other country; and

WHEREAS, Because of this and because also of the much greater individualism which is an integral part of our heritage, it is our belief that none of the systems of compulsory health insurance in effect in any other country is applicable to conditions here or furnishes any reliable criterion upon which to base such a system for the country or State; and

WHEREAS, Careful study of the problem quickly reveals innumerable difficulties inherent in any attempt to transplant or adopt any European system to the conditions existing here; and

WHEREAS, Improperly conceived plans have and will inevitably result in deterioration of the quality of the medical care supplied to the insured; and

WHEREAS, Experience has shown that the widely varying conditions found in different localities result in plans which may be satisfactory in one section, proving utterly unsuitable for another district; and

WHEREAS, For these reasons the medical profession is attempting to learn the difficulties inherent in any plan aiming at a solution of this problem, and there are now in effect over 150 different schemes in localities scattered over the entire country; and

WHEREAS, We believe it would be definitely detrimental to the public interest were measures for compulsory health insurance placed upon the statute bocks at this time; and

WHEREAS, We further believe that in view of the experiments now being conducted by the medical profession which have brought to light many serious difficulties which could not have been foreseen, the solution of which can be found only by experience, that further time should be permitted them to arrive at a solution of the entire problem which shall be free from the defects inherent in all plans heretofore in effect, and which must inevitably creep into any plan which is based upon purely theoretical considerations, which are all that are available as yet; now therefore be it

Resolved, That it is the opinion of the House of Delegates of the California Medical Association that no legislation for compulsory health insurance should be passed at the 1935 session of the legislature.

* * *

A Member: I move that we adjourn until 8 o'clock.

Another Member: I second the motion.

The Speaker: I have been requested to say that there is a Publicity Committee which will contact the newspapers, and it is requested that the members do not talk to reporters.

Doctor Wilson: A motion to adjourn takes precedence, but today we agreed to meet tonight at 8 o'clock. I doubt seriously if Reference Committee No. 2 that has been sitting here in the discussions this afternoon, and from the progress that Committee No. 1 is making they will be able to make a comprehensive report tonight, and in view of the fact that a general discussion has been made available this afternoon, I will move for a reconsideration of the question as to when we should meet again.

A Doctor: I second the motion.

The Speaker: If there is no objection, we will put the motion. It is moved and seconded that we reconsider the motion whereby we agreed to have an evening session. Any remarks? Those in favor say aye. Opposed, no. Carried.

Doctor Wilson: I move that the House meet tomorrow morning as previously scheduled at 10 o'clock.

Doctor Powell: I second the motion.

Voices: Make it 9 o'clock.

Doctor Powell: Nine o'clock will be all right.

The Speaker: It is moved that when we adjourn we meet at 9 o'clock tomorrow morning. Is there a second?

Doctor Powell: Yes.

The Speaker: Are there any remarks?

Doctor Kelly: Just one moment, please. I am speaking for the secretary who has this unusual California voice that he apologized for. The Council voted to pay the railroad fare and the lower Pullman berth both ways of all delegates who had to buy railroad tickets and lower Pullman, and if you will send a statement of your expense to the secretary, or leave it with him during the session here, as soon as we get back to San Francisco checks will be mailed to you. If you drove your automobile you will be paid your railroad fare from where you came, and we will find out what the railroad fare would have been and send an equivalent check.

(Thereupon an adjournment was taken for the day.)

Minutes of the Meeting of the Second Day

Sunday, March 3, 1935, 9 o'clock a. m.

The Speaker: We will now listen to the roll call.

The Secretary: Mr. Speaker, your secretary holds in his hand the signed attendance slips of ninety-four delegates, and recommends that some delegate move that these attendance slips and those presented later constitute the roll call of this second session of this special session.

Doctor Chandler: I so move.

Doctor Reiss: I second the motion.

The Speaker: It is moved and seconded that this be the roll call. All those in favor say aye. Those opposed, no. Carried.

Now, gentlemen, we are ready for the report of the two reference committees, and it has been suggested that we handle it in this way, that the Reference Committee No. 1 read its report, with its recommendations, and then Reference Committee No. 2 read its report, with its recommendations. In that way you will get a picture of the whole thing, not one side without the other, and then we will go back and take up the recommendations of Committee No. 1 and pass on them. Is there any objection to that way of considering it? If not, Doctor Gilman will read the report of Reference Committee No. 1, with the recommendations of the committee thereon.

REPORT OF REFERENCE COMMITTEE No. 1

Doctor Gilman: Mr. Speaker and members of the House of Delegates: Your Reference Committee in taking up the resolution submitted by Doctor Scott—do you wish that resolution read? It is recommended at the suggestion of the author that it be withdrawn.

The Speaker: There is no objection?

RESOLUTION NO. 1, INTRODUCED BY DR. INGBER

Doctor Gilman: In respect to Resolution No. 1 introduced by Irving Ingber of San Francisco, this resolution your committee renders no report on, by consent of its author. Do you wish it read?

The Speaker: Will you read it, Doctor, please?

(Said resolution read.)

Doctor Ingber: That is not the resolution, sir. Here is the copy of the resolution that was handed to me and that was asked to be withdrawn.

Doctor Gilman: I have said that was my recommendation, sir, to withdraw this resolution, and some one requested to have it read.

Doctor Ingber: I thought it was withdrawn. Pardon me, sir.

Doctor Gilman: Repeating it, then, we rendered no report on this, at the request of the author.

The Speaker: If there is no objection, this will be considered withdrawn.

Doctor Gilman: Report of the Committee of Five.

(Report read.)

The Speaker: No action will be taken at this time.

RESOLUTION AND REPORT OF THE COMMITTEE OF ONE (DR. KILGORE) ON A PLAN FOR VOLUNTARY INSURANCE

Doctor Gilman: Report and resolution of the Committee of One for voluntary health insurance, which is presented in the majority report of the Committee of Five. This report as submitted consists of one, a preamble, and two, an outline of the plan; three, a resolution embodying the principles of voluntary health insurance to be considered by the California Medical Association.

Doctor Gilman: The minority report of the Committee of Five.

(Report read.)

RESOLUTION OFFERED BY DOCTOR HOWSON

Doctor Gilman: The resolution submitted by Doctor Howson.

(Resolution read.)

Doctor Gilman: Council recommendations. These were referred to the No. 2 Committee, and by that committee referred, in part, back to Committee No. 1.

(Resolution read.)

RESOLUTION NO. 2, INTRODUCED BY DOCTOR INGBER

Doctor Gilman: Finally, Resolution No. 2, introduced by Dr. Irving Ingber of San Francisco. The resolution reads:

(Resolution read.)

Doctor Gilman: That is the original resolution as introduced. Your committee has amended this resolution to read as follows:

(Resolution read.)

Doctor Gilman: Your committee recommends amending the above amended resolution to read as follows:

(Resolution read.)

Deleting the word "mandatory" as to certain population groups and "voluntary" as to certain population groups.

REPORT OF REFERENCE COMMITTEE No. 2

The Speaker: We will now ask the chairman of Reference Committee No. 2, to read the report of that committee.

Doctor Howson: Mr. Speaker and members of the House: Your Reference Committee No. 2 reports as follows:

(Reads report.)

Doctor Howson: I may say that the amendments made by the committee were matters of phraseology only.

COUNCIL RESOLUTION B

Council Resolution B, as amended.

(Reads resolution.)

Your committee recommends that this do pass.

COUNCIL RESOLUTION C

Council Resolution C.

(Reads resolution.)

Your committee recommends that this do pass.

RESOLUTION INTRODUCED BY DR. ANDERSON

Resolution presented by Dr. C. Max Anderson, as amended.

(Resolution read.)

This has been submitted without recommendation.

The second portion of the resolution submitted by Doctor Anderson now incorporated in a separate resolution reads as follows:

(Resolution read.)

This resolution is submitted without recommendation.

ACTION OF HOUSE ON COMMITTEE REPORTS

The Speaker: We will now take up the different recommendations of these two committees for action.

Doctor Gilman: Mr. Speaker: Your Committee No. 1 would like to introduce a further resolution, an emergency resolution, which was unavoidably delayed in being typewritten this morning, if such is possible.

The Speaker: If there is no objection we will hear the resolution and consider it.

Doctor Gilman: (Reads resolution.)

The Speaker: I think this would properly come from the Reference Committee No. 2, and I think it probably should be considered last, and if there is no objection we will consider it last. We had better have these all re-read, so we will know what we are acting upon. Please read the first recommendation.

* * *

Doctor Gilman:

REPORT OF COMMITTEE OF FIVE

WHEREAS, After the expenditure of eight months' time and a large sum of money, with the coöperation and financial support of the Federal and State governments, in a study of the problem of adequate medical care for the people of California, the Committee of Five has rendered the attached report; and

Whereas, The report represents a most valuable and comprehensive contribution; therefore be it

Resolved, That the Committee of Five be assured of the gratitude and appreciation of the California Medical Association.

Your Reference Committee recommends the adoption of this report and this resolution.

F. N. Scatena
C. G. Goin
P. L. Gilman

Doctor Gilman: I recommend the adoption of this resolution as amended.

The Speaker: Is there a motion?

Doctor Crosby: I move its adoption.

Doctor Kerr: I second it.

The Speaker: It is moved by Doctor Crosby and seconded by Doctor Kerr that this resolution be adopted. Are there any remarks? Those in favor say aye. Those opposed, say no. It is carried.

* * *

Doctor Gilman: Report and resolution of the Committee of One for voluntary health insurance.

REPORT AND RESOLUTION OF THE COMMITTEE OF ONE FOR VOLUNTARY INSURANCE (PRESENTED IN THE MAJORITY REPORT OF THE COMMITTEE OF FIVE)

This report as submitted consists of:

1. A preamble;
2. An outline of a plan;
3. A resolution embodying the principles of a voluntary health insurance plan to be considered by the California Medical Association.

Your committee recommends that the report be amended to delete x-ray, laboratory, and anesthesia from the hospital services. If the House of Delegates adopt the principle contained in this report as amended, the House of Delegates should not commit itself to the detailed provisions of the specific plan (Part II of the report), but should have the Council or other delegated body free to modify details after conference with all other interests involved, and to adopt and support any plan of voluntary service consistent with said principles.

Your Reference Committee recommends the combination of the preamble and resolution submitted with another resolution at this time.

F. N. Scatena
P. K. Gilman
Lowell S. Goin

That is the recommendation of your committee, and the one to which we have referred in the reading of this report of the Committee of One for compulsory insurance.

* * *

Doctor Chandler: I arise to a point of information only. In voting on these resolutions, are we to be governed by a two-thirds majority or a bare 51 per cent?

The Speaker: Fifty-one per cent.

Doctor Chandler: I move that we adopt no resolution except by a two-thirds majority in favor of it.

The Speaker: Is there a second?

Doctor Scott: I second it.

The Speaker: It is moved by Doctor Chandler and seconded by Doctor Scott that a two-thirds majority be required to adopt any of these resolutions.

The Speaker: It has been moved and seconded that a two-thirds majority vote be required to adopt any of these resolutions. Those of you in favor will say aye. Opposed, no. The Chair is unable to determine. Those in favor will please rise and remain standing.

The Secretary: Forty.

The Speaker: Those opposed will please rise and remain standing.

The Secretary: There are sufficient rising to defeat it.

The Speaker: The motion is lost.

* * *

The Speaker: Now, gentlemen, a motion is in order in regard to the adoption of the resolution just read.

Doctor Gilman: The chairman of Reference Committee No. 1 moves the adoption of this resolution.

The Speaker: Is there a second?

Doctor Powell: I request the privilege of the floor to discuss it.

The Speaker: The motion has not been seconded yet.

Doctor Maxon: I will second it.

The Speaker: It is now open for discussion. Doctor Powell.

The Speaker: I think that we should discuss this fully, and I don't think that anybody who wants to talk should be kept from talking.

Doctor Ingber: I move to recess for one hour.

The Speaker: Is there a second?

A Doctor: I second it.

The Speaker: All in favor of recessing for one hour say aye. Those opposed, no. The ayes have it.

(Whereupon a recess was taken for one hour.)

RECESS OF ONE HOUR

The House reconvened at 1:30 p. m.

The Speaker: I would like to announce at this time that we are still in executive session as passed by resolution yesterday, but if there is no objection the members of the State Dental Executive Board of the State Dental Society are meeting across the street, and I think if any of those men come over we will ask them to take seats in the back of the hall, if there is no objection. I would like to appoint a press release committee at this time, if there is no objection, consisting of Doctors J. B. Harris, Philip Gilman, William Molony, Harry Wilson, and George Kress, so that if any of the rest of you are approached by newspaper men, please refer them to the committee. Also the chairman of the Council, and the secretary, are appointed a committee to edit the minutes of this session and have them printed. Any inaccuracies will be corrected at the annual meeting at Yosemite.

Now, gentlemen, there are a number of our members from out of town who have to catch evening trains, and we do not want those men to have to go before these very important things are acted upon. Now, while there is no desire or inclination in the world to limit discussion, we will have to bear that in mind.

Doctor Wilson spoke.

Discussion was participated in by Doctors Powell, Shepherd, Ullmann, Lawson, Packard, Foster, Yoell, Wilson, Broaddus, Anderson, Sciaroni.

* * *

The Speaker: Those in favor of having the question without further debate, please say aye. Those opposed, no. Those in favor of limiting the debate on the question, say aye. Those opposed, no. Carried. It is moved and seconded that the recommendations of the committee upon this resolution be adopted.

Doctor Roblee: May we have a five-minute recess for district caucus?

The Speaker: I think we had better have the vote first.

Voices: Roll call.

The Speaker: What is the desire? Shall we have a five-minute recess for district caucus?

Voices: No.

A Voice: No, we haven't time. May the resolution be read again?

The Speaker: Do you want the resolution re-read?

Voices: No, no.

The Speaker: Those in favor will please rise. We are voting on the motion. You are voting on the adoption of the resolution and the recommendation of the committee. How many, Mr. Secretary?

The Secretary: Forty-eight.

The Speaker: Those opposed will please rise.

The Secretary: Sixty-three noes.

The Speaker: The vote is 48 for, 63 noes. The motion is lost. Doctor Gilman will read the next recommendation of the committee.

Doctor Gilman: Your committee recommends amending the above resolution as follows: Now, therefore, be it Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system which shall include the following principles:

(Reads principles.)

F. N. Scatena
P. K. Gilman
Lowell S. Goin

RESOLUTION NO. 2, INTRODUCED BY DR. IRVING S. INGBER

Whereas, The studies of the Committee of Five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

Whereas, Because of this economic situation proper medical care is beyond the reach of this population group; and

Whereas, It has been established that this problem can be alleviated by the utilization of the insurance principle; now therefore be it

Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital.

2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system.

3. There shall be no provision for cash benefits.

4. The patient shall receive adequate treatment and his physician shall receive adequate compensation.

5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended or approved by the profession; and be it further

Resolved, That the California Medical Association immediately offer its full aid and coöperation to the Interim Committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

Resolved, That there be formed a special committee authorized and empowered to act herein, constituted as follows: The Legislative Committee of the Association and three members of the Association to be appointed by the Speaker of the House.

Doctor Gilman: That is the original resolution as submitted to your committee. Your committee modified the resolution as follows:

(Reads resolution as modified by the committee.)

Your committee, after correcting and changing the resolution, as I read it, recommends amending that changed resolution as follows: (Reading changes of bill.)

I move that it pass.

The Speaker: The adoption of this resolution has been moved. Is there a second?

Doctor Chandler: I second it.

The Speaker: The motion is now open to discussion.

Doctor Ingber: After staying in the Resolution Committee until midnight last night, we all agreed and accepted certain changes in the original resolution, which contained in the paragraph thereof the lines "that the House of Delegates of the California Medical Association discuss that legislation and the proposal seeking to establish a health insurance system mandatory as to certain population groups, and voluntary as to certain population groups, which shall include the following principles," and I went home and went to bed and thought that was the end of it. This morning when I arrived here I was told that it had been changed again, although we had had no opportunity of conference, and the change then was the deletion of the mandatory and the voluntary lines. Now, I ask for consideration of the resolution on the original resolution as first amended, leaving in the mandatory and voluntary, and it is only fair that shall be done, otherwise it is no recommendation at all, and we are in a position where we sent our committee up to Sacramento after a year's work and the expenditure of $84,000, and the unanimous opinion of the Advisory Committee and the Committee of Five that something definite shall be done, and the recommendation is compulsory and voluntary, and we get up there with nothing. You cannot do that, gentlemen, and I think it is fair that this original resolution as first amended shall be the resolution which should be presented to the House.

The Speaker: The only way that can be presented, Doctor Ingber, is for someone to move that the recommendation be amended.

Doctor Yoell: I move that the recommendation be so amended: That the first amendment be submitted and received in order.

A Doctor: I second it.

The Speaker: Will someone make a motion that the recommendations of the committee be amended, and then state what those amendments are? State definitely what amendments you want to make to the recommendation as read by Doctor Gilman.

Doctor Ingber: I wish to make the amendment that the lines "mandatory as to certain population groups," and "voluntary as to certain population groups," remain in the resolution.

Doctor Yoell: I second the motion.

The Speaker: Now, of course, in voting on this amendment you are not adopting the resolution. You are only amending it for consideration. Are there any remarks?

(Cries of "Question.")

The Speaker: Those in favor of the amendment as moved will say, aye. Opposed, no. The motion seems to be lost.

Voices: No, no.

The Speaker: Those in favor will please stand. Those opposed will stand. I think that is sufficient. The motion is carried, and the amendment is adopted.*

* * *

Doctor Ingber: May I present this resolution to the House?

The Speaker: Doctor Ingber has the floor.

Doctor Ingber: I wish to present the following resolution for the consideration of the House of Delegates. (Reading:)

"Whereas, the studies of the Committee of Five—

(Reads resolution.)

Doctor Wilson: I would like to have the doctor determine first what group is going to determine what constitutes medical control, and if we accept compulsion and do recommend through the committee to the Interim Committee, and then do not get the things which we wish, are we going to withdraw and take our licking after we have committed ourselves?

(Cries of "Question.")

The Speaker: Doctor Burns.

A Voice: Is there a second?

The Speaker: Roy Brooks seconded it.

The following discussed the question: Doctors Burns, Dietrich, Harris, Molony, Moody.

The Speaker: It has been moved and seconded that the recommendation of the committee as amended be adopted.

The Speaker: It has been moved and seconded that the recommendation of the committee as amended be adopted. Those in favor say, aye.

* Editor's Note.—The Revised Ingber Resolution No. 2, as adopted by the House of Delegates on March 3, 1935, is printed in this issue on page 187.

Doctor Brooks: I move that this resolution be adopted unanimously.

Doctor Green: I second it.

The Speaker: It has been moved and seconded that the vote on this question be made unanimous. Are there any remarks?

Doctor Schaupp: We asked for an expression of opinion. I think that we should not give out misinformation as to what action happened here. I think it should not be unanimous.

Doctor Crosby: Feeling that this is fraught with many questionable things in the minds of many of us, I think that the honesty of purpose, the honesty of vision of the people who have presented this can not be questioned, but I do not think, however, that it should not be made unanimous.

The Speaker: Any other remarks?

Doctor Brooks: My idea in making this motion was this, that we live in a republican form of government, and after a question has been fully discussed, both pro and con, and then voted upon, it is the custom in this country to follow the majority, and one other thing is the effect it would have at Sacramento if we went up there with the understanding that this resolution went through the House unanimously. I think it has a second to it. If it is the pleasure of the House of Delegates that I withdraw the motion, I will be glad to do it.

(Calls of question.)

The Speaker: I think inasmuch as it is obviously not unanimous it would be better to withdraw it.

Doctor Brooks: I so do.

The Speaker: Who seconded the motion?

Doctor Green: I did.

The Speaker: Doctor Green seconded it.

Doctor Green: I withdraw it.

The Speaker: Doctor Green seconded it, but he withdraws his second, and it is withdrawn.

THE MINORITY REPORT ON THE REPORT OF THE COMMITTEE OF FIVE

Doctor Gilman: (Reading) "The minority report of the Committee of Five."

Doctor Yoell: That is my report. If it is the pleasure of the House, I will withdraw it.

The Speaker: If there is no objection, Doctor Yoell will be permitted to withdraw his report from consideration.

* * *

Doctor Gilman:

COUNCIL RECOMMENDATIONS

The questions upon which the Council has requested your determination have (with the exception here and after noted) been presented to you in the various resolutions reported upon by this committee. The one exception is:

If the House of Delegates favors a compulsory plan of health insurance, shall it be provided by legislative enactment, initiative act or constitutional amendment?

Two points are involved in this question:

(1) Would a statute passed by the legislature providing for a compulsory system be constitutional?

(2) Assuming that such a law would be constitutional, does the Association as a matter of judgment favor entering upon such a plan in which the minimum fundamental principles are of such vital importance to the public and profession by means of a legislative enactment subject to possible destructive amendment at each succeeding session of the legislature?

The committee recommends that any compulsory health insurance system approved by the House of Delegates containing the fundamental principles which it is vitally necessary to maintain should be enacted by an initiative measure. Such a measure can be so drawn that any specified provisions thereof can thereafter be amended by another initiative measure.

The committee recommends the adoption of this principle by the House and that the whole determination of this vital question rests with the House.

F. N. Scatena
P. K. Gilman
Lowell S. Goin

The Speaker: Doctor Yoell.

Doctor Yoell: I move that the matters under consideration in that report be submitted to the committee that was created by the previous motion. That is properly and technically a legal matter, and the question would necessarily be passed on by them.

I hesitate to take the floor again, but there are two very interesting points brought up here that are questions of legal technique. It would be a tremendous advantage if the fundamental points of this bill, whatever the bill is that comes up, be carried and authenticated, so to speak, by an initiative or a constitutional amendment, but apparently on the opinion of briefs of excellent attorneys, the legislature can act and then have this question referred, if it wishes, to an initiative, and if the legislature acts and any one wishes to challenge the constitutionality of that, they can do so before that is submitted to the people. If we say to this committee that they shall only wait for the constitutional initiative, we still may lose out, so if we turn this matter over to the committee and abide by the decision we can also have the legislature pass it, and call for an initiative at the same time, and we can work for that initiative.

Doctor Brooks: I second that motion.

The Speaker: Are there any other remarks? It has been moved and seconded that this matter of legislation on initiative or referendum be not determined at this time, but that it be submitted to the committee consisting of the legislative committee and of the three which has been ordered by the previous action of the House.

Doctor Chandler: There is a resolution to be referred to Committee No. 2 in the House at a later time on this matter which covers the technical features that the Legislative Committee and its counsel will need to further the purposes expressed in the first resolution.

The Speaker: Any other remarks? Those in favor say, aye. Opposed, no. It is carried. The secretary reminds me, and he is correct, that there should be a motion that the report of the Reference Committee No. 1, as amended, be adopted as a whole.

Doctor Ullmann: I make that motion.

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that the report as a whole be approved. Those in favor say aye. Opposed, no. Carried.

* * *

REPORTS OF REFERENCE COMMITTEE No. 2

The Speaker: Now, Doctor Howson, chairman of Committee No. 2.

Doctor Howson: (Reading) "Report of Reference Committee No. 2." (Reads.)

There is also the further resolution that was submitted this morning by Doctor Scatena. This resolution has been amended to read as follows:

RESOLUTION PRESENTED BY DOCTOR SCATENA AS AMENDED BY REFERENCE COMMITTEE NO. 2

Whereas, The House of Delegates of the California Medical Association have indicated their desire to support a form of sickness insurance; now, therefore, be it

Resolved, That the Council and the Legislative Committee of the Association are hereby authorized and empowered to meet any contingencies arising in the legislature or elsewhere by supporting or opposing any measures relating to medical or hospital service or sickness insurance, taking such action as will in the opinion of the Council best subserve and

fulfill the principles and the plans laid down by the House of Delegates.

Recommended do pass.

REFERENCE COMMITTEE No. 2,
L. R. CHANDLER
GEORGE H. KRESS
CARL R. HOWSON

Your committee recommends the passage of this resolution.

Doctor Bolin: I second the motion.

The Speaker: It has been moved and seconded that this resolution be adopted. Are there any remarks?

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

* * *

Doctor Howson:

COUNCIL RESOLUTION A AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, It appears that efforts may be made at the present session of the legislature to legalize the practice of medicine for profit by corporations, as insurance or otherwise; be it

Resolved, That the California Medical Association condemns and is opposed to all legislation which would be inimical to public health and/or destructive to proper standards of medical service.

Recommend do pass.

REFERENCE COMMITTEE No. 2,
L. R. CHANDLER
GEORGE H. KRESS
CARL R. HOWSON

Your committee recommends that this resolution do pass.

Doctor Madsen: I second the motion.

The Speaker: Are there any remarks? Those in favor say, aye. Opposed, no. Carried.

* * *

Doctor Howson: (Reading) As amended. (Resolution read.)

COUNCIL RESOLUTION B AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, Bills have been introduced in the legislature opening county hospitals to all who apply for admittance, even though the applicants possess the means to pay for private hospital and medical service; and

WHEREAS, The enactment of any such legislation would throw an unnecessary and unjust burden upon the taxpayers of the county, and would tend to destroy large investments in existing private hospitals; now, therefore, be it

Resolved, That the California Medical Association is strongly opposed to such legislation.

Recommend do pass.

REFERENCE COMMITTEE No. 2,
L. R. CHANDLER
GEORGE H. KRESS
CARL R. HOWSON

Your committee recommends that this resolution do pass.

Doctor Ullmann: I second it.

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

* * *

Doctor Howson: Council Resolution C, as amended. (Reads.)

COUNCIL RESOLUTION C AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, There has been no coördinated statewide plan for the care of the sick on unemployment relief in California; and

WHEREAS, The Federal Administration has recognized the fundamental character of medical care by grouping it with food, shelter and clothing in its relief plans; and

WHEREAS, The physicians of California who have been giving of their time and skill in the care of the sick on unemployment relief should not be expected to bear this burden any more than those citizens providing the other necessities of life; and

WHEREAS, The California Medical Association and various county medical associations in California have repeatedly offered and made available their services for furnishing such care, but without avail; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association deplores the delay of the Federal and State Emergency Relief Administration in establishing a proper plan in conjunction with organized medicine and its allied professional groups, and urges that all interfering matters be subordinated to the early establishment of proper medical care for the sick upon unemployment relief in California.

Recommend do pass.

REFERENCE COMMITTEE No. 2,
L. R. CHANDLER
GEORGE H. KRESS
CARL R. HOWSON

Your committee moves the adoption of that resolution.

Doctor Green: I second it.

The Speaker: Any discussion?

(Cries of, "Question.")

The Speaker: Those in favor say aye. Opposed no. Carried.

* * *

Doctor Howson: This is the first of the two resolutions into which the committee split the resolution presented by Dr. C. Max Anderson, as amended.

RESOLUTION PRESENTED BY DR. C. MAX ANDERSON, AS AMENDED BY REFERENCE COMMITTEE NO. 2

WHEREAS, It appears that the cost of medical care is at times a serious burden to the average family, and that the economic spread of its cost is not only desirable but essential to the welfare of society; and

WHEREAS, The medical profession is being pauperized, and a pauperized medical profession cannot give to the people of this country the class of medical service which they expect and demand; and

WHEREAS, The plans of medical service in Europe are unsatisfactory for this country; and

WHEREAS, Most of the plans being advanced in this country are the entering wedge for socialized medicine, which we oppose as inimical to the best interests of society and the profession; and

WHEREAS, We believe that the free choice of physician is essential to the proper physician-patient relationship; and

WHEREAS, We believe there should be no intervention of laymen between doctor and patient; and

WHEREAS, There should be no regimentation and subjugation of the medical profession by lay authority; and

WHEREAS, Commercialization of medicine is to be avoided; and

WHEREAS, Political abuses are inherent in most schemes of health insurance; and

WHEREAS, We are opposed to the medical profession entering the insurance field itself; and

WHEREAS, We believe a limited insurance association subsidized and controlled by the State is the best and most satisfactory solution of the problem; now, therefore, be it

Resolved, By this House of Delegates that a bill for a plan of mutual cash benefits for sickness on a true insurance basis, payment being made to the insured in cash and not in service, be prepared by the proper

committee and presented to the State legislature, this payment to be in such form that the insured could apply it only to payment for medical care.

Submitted without recommendation.

Reference Committee, No. 2,
L. R. Chandler
George H. Kress
Carl R. Howson

This resolution is submitted without recommendation.

Doctor Moody: I move its passage.

Doctor Ingber: I second it.

The Speaker: Any discussion?

(Cries of question.)

The Speaker: Those in favor say aye. Opposed no. I believe I will ask Doctor Howson to read that again. There seems to be a little bit of doubt about what it is.

(Resolution again read.)

The Speaker: We will take the vote again. Are there any remarks?

Doctor Shephard: There is just one thing that comes to my mind in reference to that resolution. It can be very easily interpreted from the standpoint of the socially-minded individual that they will leave it up to that Board on furthering their ideas of opening the county hospitals and having the indigent taken care of by a full paid staff, such as they are trying to do over in Kern County. While I think we are all in sympathy with the amending of the resolution and what the Doctor has in mind, but as a matter of political expediency it might be well to keep quiet on it at this time.

The Speaker: Any further remarks? Those in favor will say, aye. Opposed, no. The motion seems to be lost. The motion is lost.

* * *

Doctor Howson: The second resolution by Doctor Anderson.

RESOLUTION PRESENTED BY DR. C. MAX ANDERSON, AS AMENDED BY REFERENCE COMMITTEE NO. 2

Whereas, The medical profession have too long carried the load of the cost of sickness of the indigent patient; and

Whereas, The large class of people unable to pay for medical care is the responsibility of the public; now, therefore, be it

Resolved, By this House of Delegates in special session assembled, that it is the sense of these delegates that the financial burden of medical care for the indigent should be lifted from the backs of the members of the medical profession and placed where it belongs as a financial responsibility of the public.

Submitted without recommendation.

Reference Committee No. 2,
L. R. Chandler
George H. Kress
Carl R. Howson

This resolution is submitted by your committee without recommendation.

The Speaker: A motion is now in order.

Doctor Porter: I move it do not pass.

Doctor Crosby: I second the motion.

The Speaker: Doctor Porter moves it do not pass, and that is seconded by Doctor Crosby. Those in favor say, aye. Those opposed, no. Carried.

* * *

Doctor Howson: I move the report of the committee as a whole be adopted.

Doctor Reiss: I second it.

The Speaker: It is moved and seconded that the report of Reference Committee No. 2 be adopted as a whole. Any remarks? Those in favor say, aye. Opposed, no. Carried. We are almost through, gentlemen.

RESOLUTION OF THANKS TO THE LOS ANGELES COUNTY MEDICAL ASSOCIATION

Doctor Ingber: I wish to present this resolution:

Resolved, That it is the sense of this House of Delegates that we thank the Los Angeles County Medical Association for the very unusual courtesies they have extended us; for the very gracious reception they have given us in this beautiful and most convenient place of assembly; for the splendid spreading of the fat of the land on their tables so that we might be fortified to proceed with our deliberations; and lastly, because the spirit of good fellowship which they did so much to create has made it possible that we carry home to our confrères the message that at Los Angeles in March, 1935, California medicine met its responsibilities.

Doctor Powell: I second it.

The Speaker: You have heard the motion. Are there any remarks?

Doctor Kelly: I would like to amend it to read that in addition to all of those things, which we thank them for in the first paragraph, that we thank them for the thunder storm yesterday afternoon.

The Speaker: That will go to the weather man. (Laughter.) Those in favor say aye. Opposed, no. Carried. The ayes seem to have it. The motion is carried.

RESOLUTION ON COÖPERATION WITH SENATE INTERIM COMMITTEE

Doctor Molony: Mr. Speaker: I wish to present the following resolution:

Resolved, That the House of Delegates of the California Medical Association, in special session assembled at Los Angeles, California, this third day of March, 1935, hereby expresses its thanks and appreciation to the Interim Committee of the Senate of the State of California, consisting of Honorable Dan E. Williams (chairman), Honorable Edward H. Tickle, and the Honorable Leonard Difani, and Celestine Sullivan, for its coöperation with the Committee of Five and the Council of this Association in the study of problems of sickness costs and sickness insurance.

Doctor Molony: I move its adoption.

Doctor Ingber: I second the motion.

Doctor Yoell: I would like to amend that motion to include the secretary of that coördination committee, who has a definite function.

Doctor Kelly: I second it.

The Speaker: It is moved and seconded that the resolution be amended to include the coördinating secretary. Are there any remarks? Those in favor say aye. Opposed, no. The vote is now upon the original motion, as amended. Any remarks? Those in favor say, aye. Opposed, no. It is carried. I would like at this time to reannounce this Press Committee. Many of you who were not here did not hear that: Doctors J. B. Harris, Philip Gilman, William Molony, Harry Wilson, and George H. Kress. Please refer all newspapermen to this committee. Now, there will be a Council meeting immediately following our adjournment. Now, gentlemen, we have lots of time. We have heard a lot of good oratory, but we have time for a little more, and I am going to, without any warning to him, call on the president of the California Medical Association to address you. (Applause.)

REMARKS BY PRESIDENT TOLAND

Doctor Toland: Mr. Speaker and members of the House of Delegates: You know the Los Angeles County Medical Association—of course I can't help speak for it because I live here—certainly feels grateful to you and highly complimented by your presence during these deliberations. I want to say to you that I think I have heard some of the best arguments, both pro and con, during this meeting of any meeting of any other House of Delegates I ever attended. Some very consistent things were said, and some very good things were done, and you men have voted to do certain things. If we will carry on and stick together, we can do it. Let's work it out to a real great end.

I wish to say that the California Medical Association should compliment its Committee of Five for the enormous amount of work it has done. I have had the privilege to be present at several meetings, and it was an all-day meeting every time. The work was thoroughly done, and without any particular thought of trying to disturb any one group of men in this profession, be-

cause they were trying to come to some conclusion that would help you and help the people of the State of California. I wish to say they are great men, all of whom would be a credit to the profession of any state. I have had an opportunity to visit many of the county medical societies of the State where I have met many brilliant doctors all endeavoring to do something worth while for their fellow man and their colleagues.

Dr. Dodd, who is the director of the survey, has worked all the time. He has traveled up and down the coast not only in this state but other states and even in the east to obtain data that might have some bearing on our survey.

I wish you all to remember that the Interim Committee, when they have met with the members of the Council, have laid their cards on the table showing they are anxious to coöperate with us. Our Council and our Legislative Committee have shown the same spirit toward the Interim Committee.

I want to thank you very much and assure you that we of the Los Angeles County Medical Association appreciate the opportunity to entertain you during your stay in Los Angeles. Thank you.

RESOLUTION OF THANKS TO THE COMMITTEE OF FIVE, THE DIRECTORS OF THE SURVEY, AND THE ADVISORY COMMITTEE

Doctor Ingber: Mr. Chairman, if a resolution is in order, I would like to have a resolution passed thanking Doctor Dodd and the Advisory Committee, the Committee of Five, for their painstaking efforts in giving us one of the finest surveys ever made in the United States.

The Speaker: Doctor Dodd and staff.

Doctor Ingber: Yes, sir, and the advisory staff.

Doctor Landrock: I second it.

The Speaker: It is seconded by Doctor Landrock of Marin County. Any remarks? Those in favor say, aye. Opposed, no. Carried.

REMARKS BY PRESIDENT-ELECT PEERS

Now, gentlemen, I am sure you have enjoyed the address of the president, and I am sure you will enjoy the address of the president-elect just as well. (Applause.)

Doctor Peers: Mr. Speaker, and members of the House of Delegates: I thank you very much for that reception, as I also thank you for the great honor that you have given me last year. I want to say that I agree with the remarks of our president, except perhaps as they referred to the Committee of Five. I think that we should all work together. I want to assure that, as an elected officer of this Association, elected by this House of Delegates, I will do everything in my power to carry out the wishes of the House of Delegates. (Applause.)

REMARKS BY VICE-SPEAKER GRAVES

The Speaker: Now, gentlemen, we have with us one of our officers who has not had a great deal to do because of my own selfishness, and that is the vice-speaker, Dr. John Graves.

Doctor Graves: Gentlemen: I would like to have you just understand that I not only agree, but like to repeat over and over again all the fine things that have been said of these committees, the Los Angeles County Medical Society, and all of the lovely things that you are entitled to.

A few years ago, three or four years ago, Ray Lyman Wilbur said—and as usual it has worked out that way—that the college professor is wrong, that the only way that the medical profession would ever go into any kind of a health insurance plan would be by the same method that a cat went across the carpet when you grabbed him by the tail and pulled him backward. (Laughter.) Now, we have proven that our good friend Doctor Wilbur was wrong, because you are not going across the carpet backward with a legislative committee on the part of the State of California pulling your tail. On the other hand, you are going like Colonel Roosevelt did at San Juan. When somebody complimented him upon his bravery in leading that charge, he said, "I didn't lead it, I had to go like hell to keep the boys from running over me." (Laughter.)

And so in that spirit, going ahead, shoulder to shoulder, and with a sure foot, I am sure that we will do a great deal for the people of California, and we are also going to protect all of our own legitimate interests, and even make things better. Thank you. (Applause.)

REMARKS BY COUNCIL CHAIRMAN KELLY

The Speaker: Now, gentlemen, there is one part of this Association which sometimes I think has not been fully appreciated, and that is the Council. I know after the adjournment of the Riverside meeting, which meeting lasted until 2 o'clock in the morning, I never was at any other time in my life so fatigued, and it was not because of the House of Delegates' meeting either. It was because of those Council meetings that drag on and drag on. We cannot help it. There was so much work to do. We met all day Friday, and all forenoon Saturday, and we had an adjourned meeting last night, and now we have another meeting tonight after we get through, and I am going to call on Tom Kelly, the chairman of the Council.

Doctor Kelly: Because the Council has to have an adjourned meeting after this House adjourns, I am going to make this short. I only want to express my appreciation at the way the Council has worked this year, and there has been plenty of work for the Council to do this year. The other thing that I want to say to the House of Delegates is that we sat here today and we voted a new departure in the medical practice in the United States. It was not an unanimous vote, and you could put me down in the book that I didn't vote to make it unanimous because I think that in this departure the men who didn't agree with it should still be on record as not having agreed with it, but that is the action of the House of Delegates and I want to urge all the delegates, no matter how they voted, now to go back home and to carry out what the House did, not try to put any sand in the gear boxes, because we are going to have a fine job at Sacramento, no matter how coöperative the Interim Committee itself is, in keeping the principles that we want to see in any bill that may be presented to the legislature, and the work of the Special Committee that was appointed today in the resolution to see that the bill was made up in the best form, and the work of the Council which we will have to do, and all of the work mentioned, will be materially aided by the solid front that Doctor Graves talked about. We have a job to do now. I don't think, unless some of you have had more or less contact with that legislature, that you realize what the committee has got to do in the next three or four months, and the only thing that will ease its work at all is a message from each one of you men back to his own county society to forget now that there are three kinds of medical practice, there is just one that we are going after at the present time to have it the way we want it. Thank you. (Applause.)

REMARKS BY SECRETARY WARNSHUIS

The Speaker: I have been trying to persuade our secretary to speak, but he says no, and I am going to call on him anyway. Dr. Fred Warnshuis.

Doctor Warnshuis: Mr. Speaker, President Toland, and President-Elect Doctor Peers, and members of the House of Delegates: I desire to express to you my sincere appreciation of the kind and cordial reception that you have given to me, and I want to embrace this opportunity of stating to you that as secretary of your Association I have no other object than to serve you and to carry out your wishes, and that whenever this office can be of service to you it is yours to command, and we shall respond. I thank you. (Applause.)

REMARKS BY CHAIRMAN HARRIS OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The Speaker: Now, there is just one other man that I want to call on, and then a motion to adjourn will be in order. Since the Riverside meeting the body that

has been holding big in the California Medical Association has been the Committee of Five, but their work is about finished. The House of Delegates, which is the supreme body in the California Medical Association, has met here and they have accepted with approval the work of that committee. Now, the thing that is going to loom big in the next three months is this newly-created Legislative Committee, the three members of the Legislative Committee, as that committee already exists, and the three yet to be appointed. I am going to call on the chairman of the present Legislative Committee, Dr. J. B. Harris.

Doctor Harris: Mr. Speaker and members of the House of Delegates: I know that we have a big job before us, not only going through and watching for these Nubians in the woodpile, but of doing the work of putting forward this wonderful constructive business of legislation that you have handed us today. Luckily, I am physically now in good shape to carry on this work. (Applause.) I am like the Dutchman who was bet that he could not drink a bucket of beer without taking a breath, and he went out and returned in a few minutes and wiped off his mouth, and he says, "I can do it, I will bet you." (Laughter.)

I have been down for an extended vacation to Palm Springs. I have called on every member, I think, of the profession that does eye, nose and throat work and asked his advice, and they all told me to go to Palm Springs and get out of the fogs that exist in Sacramento—and it is pretty foggy there at times—and to get in the sunshine, and so I went out to Palm Springs. We saw cloudbursts and floods, thunder and lightning, snow-storms and sand-storms, and we went through rigors that would bring tears to the eyes of Admiral Byrd when I go to him and tell him about it.

A Voice: Did you get well?

Doctor Harris: Yes. I had to get well. I will fight to the finish. That is why I am so confident I will be able to carry on with this work. (Applause.)

The Speaker: Knowing June so well, I can't leave this hall without asking you to remember that I call upon all of you fellows here for a rising vote for June's past record in our behalf.

(A rising vote.)

ADJOURNMENT

Doctor Kelly: I move we adjourn, Mr. Speaker.

Doctor Ingber. I second the motion.

The Speaker: Those in favor will say, aye. Opposed, no. It seems to have carried.

Attest: F. C. Warnshuis, *Secretary.*

DELEGATES ATTENDING SPECIAL SESSION AT LOS ANGELES ON MARCH 2–3, 1935

(Note: Figures following names indicate dates of attendance)

(Ex officio)	March
Toland, Clarence G.	2-3
Peers, Robert A.	2-3
Pallette, Edw. M.	2-3
Graves, John H.	2-3
Kelly, T. Henshaw	2-3
Gibbons, M. R.	2-3
Schaupp, Karl L.	2-3
Dukes, Charles A.	2-3
Kress, George H.	2-3
Roblee, W. W.	2-3
Howson, Carl R.	2-3
Ullmann, Henry J.	2-3
DeLappe, Fred R.	2-3
Phillips, Alfred L.	2-3
Hamlin, O. D.	2-3
Schoff, C. E.	2-3
Rogers, Henry S.	2-3
Wilson, Harry H.	2-3
Tanner, C. O.	2-3
Kiger, W. H.	2-3
Harris, J. B.	2-3
Alameda County	
Adams, L. P.	2-3
Crosby, Daniel	2-3
Dukes, C. A.	2-3
Moore, Gertrude	2-3
Glenn, R. A.	2-3
Lawson, T. C.	2-3
Makinson, F. R.	2-3
Meads, A. M.	2-3
Sargent, W. H.	2-3
Butte County	
Enloe, N. T.	2-3
Contra Costa County	
Abbott, U. S.	2-3
Fresno County	
Sciaroni, George H.	2-3
Madden, Thomas	2-3
Walker, George W.	2-3
Humboldt County	
No delegate present	
Imperial County	
Holleran, G. C.	2-3
Kern County	
Packard, L. A.	2-3
Kings County	
Pratt, B. H.	2-3
Lassen-Plumas Counties	
Martin, G. S.	2-3
Marin County	
Landrock, George M.	2-3
Mendocino County	
Cushman, Ruggles A.	2-3
Merced County	
Parker, A. S.	2-3
Monterey County	
Wolfsohn, Mast	2-3
Napa County	
Dawson, George I.	2-3
Orange County	
Ball, D. R.	2-3
Huffman, H. G.	2-3
Maroon, S. J. L.	2-3
Placer County	
No delegate present	
Los Angeles County	
Anderson, C. Max	2-3
Axline, Joseph T.	2-3
Blong, Peter H.	2-3
*Breyer, J. H.	
Briggs, Wilford	2-3
*Brown, Harry W.	
Burns, E. M.	2-3
Clarke, Fred B.	2-3
Crossan, John W.	2-3
Crane, Jay J.	2-3
Daniel, Wm. H.	2-3
Dietrich, Henry	2-3
Dock, George	2
*Dunlop, John	
Ghrist, Orrie E.	2-3
Gleeten, Scott D.	2-3
Godwin, Deon E.	2-3
Goin, Lowell S.	2-3
*Klein, J. M.	
Madsen, Leo J.	2-3
Maner, George D.	2-3
McKee, W. C.	2-3
Molony, Wm. R., Sr.	2-3
Moody, E. Earl	2-3
Nuttal, John P.	2-3
Ramsay, Robert E.	2-3
Reiss, Oscar	2-3
Ruddock, John C.	2-3
Scott, A. J.	2-3
Wessels, Walter	2-3
Snure, Henry	2-3
Stephens, Philip	2-3
Sturgeon, Charles T.	2-3
*Swindt, Joseph H.	
Webber, W. T.	3
Wilcox, Robert W.	2-3
Alternates	
Pottenger, F. M.	2
Shuman, John	2-3
Larsen, Eric	2-3
Riverside County	
Carl, Thomas A.	2-3
Coon, G. Wayland	2-3
Sacramento County	
Hale, Nathan	3
Briggs, G. A.	2-3
Scatena, Frederick	2-3
San Benito County	
No delegate present	
San Bernardino County	
Gage, A. T.	2
Hull, E. H.	2-3
Whitmer, C. F.	2
Gentry, H. G.	3
San Diego County	
Garth, W. L.	2-3
Holder, Hall G.	2-3
Huff, George D.	2-3
*Ledford, R. M.	
McClendon, S. J.	2-3
Kinney, Lyell C.	3
San Francisco County	
Bolin, Zera	2-3
Brooks, LeRoy	2-3
Bruck, Edwin L.	2-3
Chandler, L. R.	2-3
Garland, L. H.	2-3
Gilman, Philip	2-3
Hosford, George N.	2-3
Ingber, Irving	2-3
Kerr, Wm. J.	2-3
Kilgore, Alson	2-3
Pierce, George W.	2-3
Porter, Langley	2-3
Swett, Wilber F.	2-3
Rhodes, George K.	2-3
Thorne, I. W.	2-3
Yoell, Rodney A.	2-3
San Joaquin County	
Powell, Dewey	2-3
Broaddus, C. A.	2-3
San Luis Obispo County	
Sobey, G. L.	2-3
San Mateo County	
Ray Hartzell H.	2-3
Santa Barbara County	
Evans, Richard	2-3
Freidell, Hugh	2-3
Santa Clara County	
Canelo, C. Kelly	2-3
Kneeshaw, R. Stanley	2-3
Van Dalsem, S. B.	2-3
Shephard, J. H.	2-3
Santa Cruz County	
No delegate present	
Shasta County	
No delegate present	
Siskiyou County	
Hart, V. W.	2-3
Solano County	
Green, John W.	2-3
Sonoma County	
Butler, F. O.	2-3
Stanislaus County	
Hartman, Hans	2-3
Tehama County	
Frey, R. G.	2-3
Tulare County	
Kohn, Frank	2-3
Ventura County	
Morrison, A. R.	2-3
Yolo-Colusa-Glenn Counties	
Poage, C. A.	2-3
Yuba-Sutter Counties	
Hamilton, R. L.	2

* Did not attend.

ADDENDA

MISCELLANEOUS RESOLUTIONS AND REFERENCES ON THE SUBJECT OF SICKNESS INSURANCE

Report of Reference Committee — Special Session, House of Delegates of the American Medical Asssociation, February 15 and 16, 1935. — Your Reference Committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available to the American people, condemns unreservedly all propaganda, legislation or political manipulation leading to these ends.

Your Reference Committee has given careful consideration to the record by the Board of Trustees of the previous actions of this House of Delegates concerning sickness insurance and organized medical care and to the account of the measures taken by the Board of Trustees and the officials of the Association to present this point of view to the Government and to the people.

The American Medical Association, embracing in its membership some one hundred thousand of the physicians of the United States, is by far the largest medical organization in this country. The House of

Delegates would point out that the *American Medical Association is the only medical organization open to all reputable physicians and established on truly democratic principles, and that this House of Delegates, as constituted, is the only body truly representative of the medical profession.*

* * *

The House of Delegates commends the Board of Trustees and the officers of the Association for their efforts in presenting correctly, maintaining and promoting the policies and principles heretofore established by this body.

The primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care, and the provision of adequate medical service to all the people. These physicians are the only body in the United States qualified by experience and training to guide and suitably control plans for the provision of medical care. The fact that the quality of medical service to the people of the United States today is better than that of any other country in the world is evidence of the extent to which the American medical profession has fulfilled its obligations.

* * *

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the governments of the individual states, or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

The medical profession has given of its utmost to the American people, not only in this but in every previous emergency. It has never required compulsion, but has always volunteered its services in anticipation of their need.

* * *

The Committee on Economic Security, appointed by the President of the United States, presented in a preliminary report to Congress on January 17 eleven principles which that committee considered fundamental to a proposed plan of compulsory health insurance. The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experience in medical practice are found by the committee to be essential to its own plans.

However, so many inconsistencies and incompatibilities are apparent in the report of the President's Committee on Economic Security thus far presented that many more facts and details are necessary for a proper consideration.

* * *

The House of Delegates recognizes the necessity under conditions of emergency for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and protests those sections of the Wagner Bill which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes.

* * *

The House of Delegates condemns as pernicious that section of the Wagner Bill which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

* * *

The so-called Epstein Bill, proposed by the American Association for Social Security now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous and demoralizing measure. An analysis of this proposed law has been published by the American Medical Association. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration, and an inevitable trend toward social and financial bankruptcy.

* * *

The committee has studied this whole matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

* * *

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June, 1934.* The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase, or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physicians on the other.

* * *

Your Reference Committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeting of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

(Signed) Dr. Harry H. Wilson, Chairman, California
Dr. Warren F. Draper, Virginia
Dr. E. F. Cody, Massachusetts
Dr. E. H. Carey, Texas
Dr. N. B. Van Etten, New York
Dr. F. S. Crockett, Indiana
Dr. W. F. Braasch, Minnesota

*Editor's Note: See page 52 of the July, 1934, issue of California and Western Medicine for a summary of the fundamental principles adopted at the Cleveland session of the American Medical Association.

State Dental Society of California Pass Resolutions on Health Insurance *

RESOLUTION ON HEALTH INSURANCE ADOPTED BY THE COUNCILS OF THE CALIFORNIA AND SOUTHERN CALIFORNIA STATE DENTAL ASSOCIATIONS

WHEREAS, The studies of the California Medical Economic Survey have shown the inability of a certain percentage of our population to adequately finance the cost entailed by dental services; and

WHEREAS, Because of this economic situation it appears that proper dental care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; and

WHEREAS, A resolution of parallel intention has been adopted by the California Medical Association covering medical and hospital attention; now therefore be it

Resolved, That the Councils of the California and Southern California State Dental Associations recommend that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of dentist and hospital.
2. The dental professions shall through their representative organization determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, dental, and dental auxiliary services rendered under the system.
3. There shall be no provision for cash benefits.
4. The patient shall receive adequate treatment and his dentist shall receive adequate compensation.
5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession.

and be it further

Resolved, That the California and Southern California State Dental Associations immediately offer their full aid and coöperation to the Interim Committee of the Senate of the State of California, charged with the study of this problem, and the California Medical Association, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

Resolved, That there be formed a special committee authorized and empowered to act herein, constituted as follows: The presidents of the California and Southern California State Dental Associations, the chairmen of the Legislative Committees of the California and Southern California State Dental Associations, J. Franklyn Cook, and Ernest G. Sloman.

Association of California Hospitals: Its Viewpoint of Sickness Insurance.—The following letter of date of March 14, has been received by the editor:

"At the San Francisco Convention of the Western Hospital Association a California state association was set up known as the Association of California Hospitals. This Association took over all activities from the Western Hospital Association which concerned California hospitals.

"As President of this Association I wish to definitely offer our coöperation with the officers of the California Medical Association in working out our many complex, mutual problems. The hospital executives of California have only one objective in mind and that is to keep the California hospitals outstanding institutions rendering a truly public service and coöperating with the doctors of medicine in keeping the hospitals on an ethical basis.

"One of the big problems facing us at the present time is compulsory health insurance. The hospitals have been studying this proposition for some time and feel that there may be some solution of the acute hospitalization problem through compulsory health insurance by holding back the inroad of government institutions, which in reality works the same handicap for the medical profession. We, however, see many pitfalls with compulsory health insurance. We are practically of one mind that compulsory health insurance must be constructed and administered by medical men. I wish to also make it very emphatic that the hospitals of this Association as a group have formulated no set program and have never proposed any plan of compulsory health insurance.

"We have a Special Committee, namely, Ellard L. Slack, G. Waite Curtis, and R. E. Heerman, who have been delegated to work with your Association and other interested groups in proposing legislation that will be of the utmost service to the public. We believe this can be accomplished and still adhere to the following basic principles:

"First: That it must give free choice of physician and hospital.

"Second: That it must insure the patient securing practically the same high quality service as he is now receiving and eliminate some of the hazards that have grown up under socialized medicine and industrial medicine.

"Third: That hospitals should be paid adequate compensation to render high class hospital service and not be subject to cut-throat competition.

"I am writing you this letter so that you might know the principles and ideals back of this Association, and our willingness to cooperate in working out a solution of the problem so that this vital service to the public may be constructed in line with the interests of the ethical doctor of medicine."

Signed

R. E. Heerman, President.
1414 South Hope Street, Los Angeles.

The Next Steps.*—In all the addresses in this series certain facts have been emphasized again and again. By common consent the maintenance and improvement of health is a primary concern of every individual and therefore of organized society. It is well known that illness is no respector of persons and constitutes the leading hazard in the life of the individual and of the family. The brilliant advances in medical knowledge of the last fifty years have greatly improved the weapons at our disposal both for the prevention and the treatment of disease, but unfortunately they remain largely unapplied. We have then two main problems confronting us as a people, first the more effective prevention of preventable disease, and second the wider availability of expert medical care. . . .

When we come to the problem of adequate medical care for the American people the steps to take are by no means so evident. There has long been a common impression that a large proportion of the public receives inadequate medical attention, but the facts brought out by the Committee on the Costs of Medical Care have shown a situation that cannot be disregarded and the condition is growing worse. . . .

Nothing could be more unjust than to charge the medical profession with responsibility. Not only the ideals but the practice of that profession entail an enormous amount of unremunerative work. In every community of the country the doctor has carried his load of unpaid service and too often without recognition of any sort. And as the years have passed the doctor's economic lot has reached a crisis. In 1929 one-third of all American physicians had net incomes of less than $2500 a year and one-half of them less than $3800. The Committee on the Costs of Medical Care found that if the incomes of private general physicians were graded

* To the Editor.—Enclosed please find a copy of the resolution adopted at a Joint Meeting of the Councils of the California and Southern California State Dental Associations in San Francisco on March 10, 1935. As you will recognize—it is nearly identical with the resolution adopted by the House of Delegates of the California State Medical Association at its meeting on Sunday, March 3, 1935, in Los Angeles.—Ernest G. Sloman, D. D.

*Excerpts from an address by Livingston Farrand, in the Public Health Series (Lecture 19). Sponsored by the National Advisory Council on Radio in Education

in income groups of $1000, more would be found in the $1000-$2000 class than in any other.

Our problem of course is not of the well-to-do or wealthy patient or of the medical specialist or general practitioner of large practice in our cities. The problem to be solved is that of the poor and middle class patient and of the average doctor, dentist and nurse.

The studies referred to have also shown that on a reasonable distribution there are nearly enough qualified physicians in the United States adequately to care for the people were it not for the unfortunate concentration of the profession in our cities. The inevitable consequence is that great rural areas are left with insufficient medical care or even totally without it.

The natural question at once arises whether, under the circumstances, the American people could afford to pay for the kind of medical service which modern knowledge indicates as desirable. The immediate answer is that the people already pay nearly enough in any normal year to buy medical service for everyone. The best estimates have shown that an expenditure of $36 per capita a year would meet the demands of reasonable standards, and conservative estimates also show that today we spend in the United States about $30 per capita a year but with the totally unsatisfactory results just described. What then is the answer?

Numerous attempts have been made and are being made by the medical profession to solve the difficulty. Group practice in various forms, local coöperative plans and devices aimed at the problem of small groups have helped the situation locally but have not significantly affected the national picture.

The only promising solution to our difficulty would seem to be some plan whereby the costs of medical care can be distributed over large groups through the application of some insurance principle. It may as well be recognized at once that people of small or moderate incomes cannot individually budget and meet the unpredictable expenses of illness, and the insurance principle, in whatever way or ways it may be worked out, offers the greatest hope of results.

This is, of course, no revolutionary proposal. Nearly all the countries of Europe in one form or another have adopted a sickness insurance plan. We are in the fortunate position of being able to profit by the experience of our sister nations and thereby to avoid some of the errors into which they have fallen.

There is no wisdom available today which can outline with certainty a health or sickness insurance plan which would be successfully applicable to the entire United States. Conditions vary not only with the geography of the country but with the industrial conditions which are characteristic of great areas. To legislate for New England as one would for the Southwest is obviously impracticable. *And it is undoubtedly wise that experiments should be tried and that no comprehensive plan in rigid terms should be forced upon the American people by hasty edict.* As is well known, this particular problem is being brought sharply into discussion and therefore to public attention by the studies and recommendations for social security emerging from Washington. If success is to be achieved certain broad principles must permeate every plan proposed.

The first and most fundamental principle is that full coöperation between the medical and dental professions and the public is essential. Any system which would tend to lower the quality of those professions would carry the seed of ultimate failure. The control of professional procedures and the maintenance of professional standards must remain in the hands of the professions charged with responsibility. The time-honored relation between patient and physician should be safeguarded in any plan. Fortunately there is no reason why these principles should be sacrificed. The problem is clearly economic and the method of payment for service is not primarily a professional matter. In the last instance it is simply a question of the capacity of the public to pay and the method of that payment will inevitably be determined by the public which pays. There is no apparent reason why systems of sickness insurance should not be devised which would work to the advantage of both physician and patient. Indeed such are already available.

I have said nothing about one aspect of this problem which is causing grave concern in all parts of the country, and that is the critical situation in which our hospitals find themselves. Private philanthropy to which so many of them have looked for support has found itself unable longer to carry the load. It is significant that these indispensable foundations are turning to group hospital insurance to meet at least a part of the unprovided costs.

I am purposely not attempting to suggest particular and specific schemes. Different states can and should try different plans and nothing but experience will indicate the best. . . .

The task of the moment and the purpose of this series of addresses is to call the people's attention to the condition which confronts them and to urge prompt but well considered action.

Medicine Moves Forward.—The American Medical Association, in coöperation with the Broadcasting Company, on February 18, 1935 put out special broadcasts under the heading "Medicine Moves Forward." The speakers were Dr. Walter L. Bierring, President of the American Medical Association, Dr. Ray Lyman Wilbur, Chairman of the Council on Education and Hospitals of the American Medical Association, and Dr. W. W. Bauer, Director of the Association's Bureau of Health and Public Instruction. Dr. Morris Fishbein, Editor of *The Journal* of the American Medical Association and of *Hygeia,* the health magazine, introduced the speakers and spoke on the subject of sickness insurance.

Dr. Fishbein stated that copies of the speeches would be available and would be sent to all who wrote to the American Medical Association, 535 North Dearborn Street, Chicago.

British Hospital Contributory Schemes (Voluntary Health Insurance).—Under this heading the March 1935 "Bulletin of the American College of Surgeons" prints an article by Sydney Lamb of Liverpool, England, General Secretary of the Merseyside Hospital Councils, Inc., in which is given a description of some of the voluntary hospital insurance plans now utilized by English workmen and their families. The article contains much interesting information on recent plans of voluntary sickness insurance and hospitalization, as now being carried out in some of the cities of England.

Sickness Bills by Installment: — Wayne (Pino) County Plan. — The March issue of the "Survey Graphic" prints an article on the "Pino Plan" for the installment payments of medical bills for services supplied by the Wayne County (Michigan) Medical Society. In the article it is stated "Health insurance lies before the states and the nation as an issue in our search for security. Detroit doctors believe they are working out a better way to get medical care for all who need it. It has been widely cited as a model . . ."

Social Insurance Costs.—"The Great Britain National Insurance Act began in a limited, experimental fashion in 1911 with some 2,250,000 workers. It applied only to certain trades. Amended half a dozen times to correct its imperfections it has had, almost from the first, a stormy existence. By 1931 it had rolled up a deficit of nearly two billion dollars (40,000,000 pounds) and royal commissions were sitting up nights to decide what was to be done about it."—*Saturday Evening Post,* December 15, 1934.

"The will to be well includes the willing of the means proper to that purpose, and particularly regular exercise, several hours a day in the air, good simple food taken in sufficient quantity at three regular intervals, and the avoidance of such sources of worry as will disturb physical functions."

CALIFORNIA MEDICAL ASSOCIATION

FREDERICK C. WARNSHUIS, M. D., Associate Editor for California

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

CLARENCE G. TOLAND.....President
ROBERT A. PEERS.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

OFFICIAL NOTICE

Reduced Railroad Fares to Yosemite Valley—Send for Certificate.—Arrangements have been made for a fare and one-third for railroad travel to and from Yosemite National Park.

If you plan to travel by train, write to the State Secretary for a certificate that will authorize your local agent to sell you a ticket at reduced rates.

You must have this certificate to obtain reduced rates.

MONTH'S ACTIVITIES

The Council held a two-day session in San Francisco. The minutes appear in this issue.

The Scientific Program Committee and section officers met on January 27 and completed details of the program for the annual session. Watch for the April issue, which will give the entire program.

California's seven delegates attended the special meeting of the American Medical Association House of Delegates in Chicago, February 15 and 16. A summary of action recorded will be found in this issue.

By action of the Council, notices of a special meeting of the Association's House of Delegates to be held in Los Angeles on March 2, and instructions, were sent to county officers and delegates who served at the 1934 session.

The Committee on Public Relations has held two sessions devoted to future plans of work and Fair exhibits.

The Committee of Five and their Advisory Council and technical staff held an all-day session in San Francisco on February 3, and a two-day session in Los Angeles on February 23 and 24.

By reason of the details and work required by and related to the national and state special meetings, it is impossible to fully report upon them in this issue. Complete information will be found in the April issue.

STATE AND COUNTY SOCIETY ACTIVITIES

REDUCED RAILROAD FARES TO YOSEMITE

Write in to the State Secretary for identification certificates for reduced railroad rates to Yosemite National Park as per attached letter.

CALIFORNIA MEDICAL ASSOCIATION—YOSEMITE VALLEY
MAY, 13-16, 1935

Your letter of January 25 regarding special fares for your convention to be held May 13-16, 1935.

For this convention, special round-trip fares to Yosemite Valley will be authorized on the identification-certificate plan on basis of 85 per cent of the current first-class one-way fare for the round trip to Merced, plus $7.25 from Merced to Yosemite Valley.

The special round-trip convention fares will apply from all points in California except from points on the Westwood and Alturas lines of the Southern Pacific in Modoc, Plumas, and Lassen counties.

From points in California on Westwood and Alturas lines of the Southern Pacific Company the lowest available round-trip fares will be ten-day round-trip coach-intermediate fares or the twenty-one-day summer round-trip fares.

Round-trip convention fares will be available only for members of your organization and dependent members of their families on presentation and surrender to railroad agent of an official identification certificate.

As requested, I shall arrange to forward you a supply of one thousand identification certificates. Certificates should be furnished to all delegates with names of those to whom furnished entered thereon with pen and ink (or typewriter).

The sale dates for tickets on the identification certificate plan from all points in California not involving an interstate trip, will be May 9 to 16, inclusive, with return limit of May 20.

The interested rail lines would very much appreciate your advising all delegates of the very low fares offered so that as many as possible will travel via rail.

Yours very truly,
G. C. HURLESS, Agent.
Southern Pacific Building.

* * *

OPPORTUNITY FOR FINANCIAL LOANS

The following information, supplied by a federal representative, should be of interest to members. Those contemplating purchase of equipment, remodeling of offices, etc., will possibly avail themselves of this opportunity to secure financial assistance.

Physicians who own their own homes or lease their offices are finding useful in their profession the provisions of the National Housing Act, the legislation in back of the better housing program now in progress throughout the country.

Under this Act, doctors whose offices or laboratories are in their homes may alter, repair or modernize their suites as well as provide or replace certain equipment for experimental or treatment work, including x-ray, under the better housing plan.

Those who are leasing office space and whose lease imposes upon them the upkeep of the property, also are as eligible as actual owners, provided the lease has a duration six months longer than the repayment of the loan.

All built-in features which are permanently attached to the property come under the provisions of the Act. Refrigeration and "x-ray" equipment must be part of the permanent wiring of the building. Needless to say, plumbing, partitions, and similar fixtures come under the Federal Housing Administration plan of finance.

The National Housing Act provides an insurance reserve to banks and other lending agencies which make installment loans at a charge not greater than at the rate of five dollars a hundred a year, the fee being payable in advance. This is the lowest interest charge ever known on loans of this kind. Loans may be made up to $2,000. Practically every bank in the country is making these loans, which usually run from one to three years.

A physician who desires to purchase permanently attached professional equipment or alterations to his property may apply to his own bank. The only requirements of the National Housing Administration are that he own the property (a mortgage in good standing is no impediment) that he expend the money for the purpose for which it was borrowed and that his income be five times the annual payments on the note. For example, to borrow $1,500 for repayment in thirty-six months, a gross income of approximately $2,500 per annum is required. Thus, the legal requirements are extremely simple.

These loans are, in fact, character loans. It is private money lent by your own bank and is not Government money. This is in no sense a relief or charity measure. It is intended to provide credit facilities to substantial people of good character and credit standing. The Government simply insures the loan; in other words, Uncle Sam endorses your note.

More than 87,000 of the highest type of American citizens have made use of Federal Housing Administration loans in the first six months of its operation. Banks and other lending institutions are coöperating fully. If there is some permanently attached piece of professional equipment that you need in your practice; if your own home needs modernization to make it more comfortable for you and your family; if your personal credit standing is good, then the National Housing Act can help you. Discuss it with your bank. Loans can be made promptly by the lending institution. Applications do not have to be submitted to the Federal Housing Administration.

The modernization features of the National Housing Act automatically expire at the end of 1935. Loans made this year will, of course, run to full maturity, but no new

loans will be made after 1935 unless Congress extends the benefits of the Act. You should, therefore, investigate this now if you desire to avail yourself of these sound credit facilities provided by your Government.

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SIXTY-FOURTH ANNUAL SESSION

The April issue will contain the completed program. At this time announcement is made of some of the high-lights of the meeting.

Out of State Guests.—President-Elect of the American Medical Association, James S. McLester, professor of Medicine, University of Alabama, Birmingham; E. Starr Judd, Mayo Clinic, Rochester, Minnesota; George H. Whipple, dean and professor of pathology of the University of Rochester School of Medicine, Rochester, New York; and Thomas P. Sprunt of Baltimore, Maryland.

Sunday, May 12.—Clinico-pathologic conference, morning and afternoon.

Monday, May 13.—Opening general meeting, president's address; addresses by E. Starr Judd and James S. McLester. Afternoon—Symposium on the Liver, with the following speakers: George H. Whipple, Thomas P. Sprunt, William J. Kerr, Verne C. Hunt, and Douglas R. Drury. House of Delegates meets in the evening.

Tuesday, May 14.—Morning section meetings. Second general meeting, with the following speakers: George H. Whipple and Thomas P. Sprunt. Afternoon—No meetings. Open for sightseeing, tennis, and golf. Evening—President's dinner; fire fall, feeding the bears, and dance.

Wednesday, May 15.—Section meetings morning and afternoon. Third general meeting, with the following speakers: James S. McLester, Deputy Attorney-General Lionel Browne, Professor Paul A. Dodd, and Harry H. Wilson, secretary of the Committee of Five on Medical Survey. House of Delegates meets in the evening.

Thursday, May 16.—Section meetings morning and afternoon.

Woman's Auxiliary.—Officers of the Auxiliary are arranging programs for business sessions and entertainment.

Hotels.—The following rates have been made:

AMERICAN PLAN

The Ahwahnee—Capacity, 225. Each room with private bath.

Two in room, $8 per person per day.
One in room, $10 per day.

Camp Curry—Capacity, 1,200.

Rooms with bath:
Two in room, $5.50 per person per day.
One in room, $7 per day.
Rooms without bath:
Two in room, $4 per person per day.
One in room, $5 per day.
Tents without bath:
Two in tent, $3.50 per person per day.
One in tent, $4.50 per day.

EUROPEAN PLAN

Yosemite Lodge—Capacity, 300.

Rooms with bath:
Two in room, $3 per person per day.
One in room, $4 per day.
Rooms without bath:
Two in room, $2 per person per day.
One in room, $3 per day.
Members should write for their reservations.

Railroads.—Special sleepers will leave Los Angeles and San Francisco on Sunday night, May 12, for Merced and El Portal. See local ticket agent for reservations. Return sleepers, Thursday night.

The Yosemite will be at its best during the days of the meeting. Plan now to go and profit by the exceptional scientific program that has been arranged. Enjoy the scenery of Yosemite Park. You will be well repaid.

SPECIAL MEETING OF THE A. M. A. HOUSE OF DELEGATES*

As announced in the previous issue, the House of Delegates of the American Medical Association was called in special session in Chicago on February 15 and 16, 1935. The object of this special session was to consider proposed and pending legislation related to federal and state health insurance proposals and programs.

The general summary of action recorded was sent by air mail immediately after the special meeting adjourned in order that our members may become informed as to what was transacted.

WORTH PONDERING OVER

"It is now, as of old, altogether probable that 'There is no new thing under the sun' in the realm of thinking. Why then should one yield to the impulsion to write and print? The answer is for the same reason that he is photographed or done in oils or marble, namely, in the hope to escape oblivion."

* * *

The dean of St. Paul's, in London, addressed a group of visiting doctors from all over the world in these words: "I greet you as defeated captains. You are always doomed to final failures in your encounters with disease."

The comment has been made that it is true enough, but we are meeting the enemy more successfully than ever before in history, and though still doomed to final failure, that finale is being put off longer and longer by reason of our greater knowledge.

* * *

The chemical humorist, Clowson, says: While sound travels at a speed of 11,000 feet per second, it often takes about twenty years to penetrate through the ear to the brain.

* * *

Texans relate the following as being their method of serving planked jack rabbit. "After parboiling the rabbit and the plank, with repeated changes of water, for a day or two, and then baking what is left for another day, the wise Texan throws the rabbit away and eats the plank."

Of the many plans advanced for social security, possibly we can parboil and bake them all on one plank, and eventually eat the plank—at least we can experiment by controlled provisions, and satisfactorily solve the whole problem.

* * *

"California Board of Professional Instructors of Golf." Cheer up, you golfers in the 100-and-up class. If Senate Bill 562 is passed you will be able to find a certified "Pro." possessed of these qualifications: eighth-grade graduate, moral temper, fit to instruct and familiar with implements used in golf. Don't patronize unlicensed "prof."

* * *

"Benjamin Franklin's adage, right a hundred and fifty years ago, is just as true today. For sleep, which takes away the tired feeling that results from the strain of modern life, does bring vitality, money and knowledge. To those of us who want a more appealing personality, sleep will bring much of the energy that gives it. Because, as tiredness changes character profoundly, it is difficult for the under-rested man or woman to have pleasing personality traits. Schopenhauer, having slept enough, might have written an optimistic philosophy."

* * *

"Modern medicine gives more attention to diet than to almost any other single factor in the control of the human body. The appetite is a fairly good guide to the time when eating should be indulged in and the quantity to be taken. It is a good rule to stop just short of satisfaction. An epicure or gourmand is hardly likely to stop at this point."

* Editor's Note.—Resolutions adopted by the House of Delegates of the American Medical Association are printed on page 207.

COUNCIL MINUTES

Minutes of the Two Hundred and Thirtieth Meeting of the Council of the California Medical Association

The following minutes were approved by the Council at its two hundred and thirty-first meeting, held at Los Angeles, Saturday, March 2, 1935.

Held in Room 210, Sir Francis Drake Hotel, Saturday, January 19, 1935, at 9:30 a. m.

Present.—Doctors C. G. Toland, president; Robert A. Peers, president-elect; E. M. Pallette, speaker; T. H. Kelly, chairman of Council; Karl L. Schaupp, chairman of Executive Committee; Councilors W. W. Roblee, H. J. Ullmann, F. R. DeLappe, A. L. Phillips, C. E. Schoff, H. S. Rogers, Harry H. Wilson, C. O. Tanner, W. H. Kiger, M. R. Gibbons; C. A. Dukes, chairman of Public Relations; George H. Kress, editor; F. C. Warnshuis, secretary; and Hartley F. Peart, general counsel.

Absent.—Doctors Carl L. Howson, O. D. Hamlin, J. B. Harris.

1. **Call to Order.**—The meeting was called to order by the chairman, T. Henshaw Kelly.

2. **Minutes of the Council.** — Secretary presented minutes of the adjourned two hundred and twenty-ninth meeting of the Council held on December 22, 1935.

Moved by Councilor Roblee, seconded by Councilor Phillips, that the minutes of the adjourned two hundred and twenty-ninth meeting of the Council be approved. Carried.

3. **Corporate Practice.**—Chairman Kelly read "An Act for the Regulation and Control of Corporations Organized for the Purpose of Operating Non-Profit Hospital Service Plans" as prepared by the San Francisco and Southern Hospital Conferences and Legislative Committee of the Western Hospital Association.

Moved by Speaker Pallette, seconded by Councilor DeLappe, that the proposed act for control of corporations operating non-profit hospital service plans be referred to the Committee on Public Relations with the request that they report back to the Executive Committee, which shall have power to act. Carried.

4. **San Diego Health Insurance Program.**—Secretary presented the plan of the San Diego County Society for health insurance under a fraternal benefit society.

Moved by President Toland, seconded by Councilor Ullmann, that the San Diego medical service plan be referred to the Committee on Public Relations with instructions to report to the Executive Committee. Carried.

5. **Philip King Brown Correspondence.** — Correspondence between P. K. Brown, the chairman, and the secretary was read to the Council.

Moved by Councilor Roblee, seconded by Councilor Schaupp, that the reply of the chairman be approved. Carried.

Moved by Chairman of Public Relations Dukes, seconded by Councilor Phillips, that in regard to the insurance practice of the Los Angeles County Medical Association, Doctor Brown be sent a copy of the Los Angeles County Medical Association Bulletin of June 18, 1931, which contains the arrangement between the Los Angeles Association and the Metropolitan Water District, and that he be further informed that the Council will be glad if he will submit any further criticism that he may have either by letter or in person. Carried.

6. **Committee of Five.**—Chairman Kelly stated the time set for the report of the Committee of Five had arrived.

Moved by Chairman of Public Relations Dukes, seconded by Speaker Pallette, that the Committee of Five be invited to submit the reports of the individual members and the committee and that no discussion be had at this time. Carried.

Dr. Charles Sweet, president of the Northern California Dental Association, sat with the Council, representing dentistry.

Professor Paul Dodd, Director of Survey, presented the preliminary report of the survey and outlined the facts contained therein. Doctor Dodd stated that the staff of the survey was not ready to make recommendations on the basis of the incomplete data contained in the preliminary report with the exception of urging that hasty legislation be not enacted.

A. R. Kilgore presented and discussed tentative principles of any compulsory or voluntary health plans submitted by the Committee of Five for discussion by the Council. Doctor Wilson suggested that the principles be submitted to the Council for consideration.

Doctor Yoell then addressed the Council asking that consideration be given to a compulsory health insurance bill he was having prepared instead of to the principles submitted by the committee. Doctors Wilson and Peers discussed the principles submitted by the committee.

7. **Noon Recess.**—At this point, on motion of Councilor Ullmann, seconded by Speaker Pallette, the Council recessed until 2 p. m. for luncheon.

8. **Coffey Correspondence.** — Correspondence from Walter B. Coffey relative to replies to inquiries received at the State office requesting information on the Coffey-Humber cancer extract, was read.

Moved by Councilor Gibbons, seconded by Wilson, that the Council inform Doctor Coffey that the secretary acted under Council instructions. Carried.

Further discussion was had by members of the Council, including Doctor Dukes, the chairman of the Cancer Commission.

Moved by Councilor Wilson, seconded by Councilor Gibbons, that the reply to Doctor Coffey include the action embodied in Doctor Gibbons' motion and the thoughts expressed by Doctor Dukes, and that the letter be signed by the chairman of the Council by order of the Council, and that the letter, before being signed, shall be approved by Doctors Gibbons and Schaupp. Carried.

9. **Illness of Doctor Hamlin.**—A message telling of the illness of Doctor Hamlin was presented and Councilor Ullman moved, seconded by Councilor Gibbons, that a telegram expressing the good wishes of the Council be sent Doctor Hamlin by Chairman Kelly.

10. **Qualifications Act.**—Editor Kress presented a revision of the proposed Qualifications Act.

Moved by Editor Kress, seconded by President Toland, that with the assistance of Doctors Gibbons, Magan, Harris, Kelly, Toland, Peers, Warnshuis, and Mr. Peart, the bill be revised and presented to the Executive Committee for consideration and power to act.

11. **Hoffman Articles.**—Editor Kress brought up the question of continuation of publication in the JOURNAL of the uncompleted series of health insurance articles by Mr. Hoffman.

Moved by Councilor Roblee, seconded by Councilor Ullmann, that publication of the articles of Mr. Hoffman be continued in the JOURNAL. Carried.

12. **Amendments to Medical Practice Act.**—Proposed amendments to medical practice act were discussed.

Moved by Editor Kress, seconded by Councilor Phillips, that the Association coöperate with the State Board of Medical Examiners in regard to legislation of medical interest. Carried.

13. **Survey of Legal Expense.**—Councilor Roblee, chairman of the Special Committee on Survey of Legal Expense, reported progress and stated that a report would be presented at the next meeting of the Council.

14. **Malpractice Insurance.**—Discussion of malpractice insurance was deferred until the next meeting of the Council.

15. **County Charters.**—General Counsel Peart brought up the matter of incorporation of provisions in County Charters to provide for legal use of county hospitals. The matter was left to the discretion of Councilor Kelly and Mr. Peart.

16. **Disciplinary Procedures.**—The General Counsel presented tentative rules to govern disciplinary procedures in county societies to be included in by-laws.

Moved by President-elect Peers, seconded by Chairman Public Relations Dukes, that the by-laws governing disciplinary procedures in county societies be left to the approval of Doctors Toland, Kelly and Warnshuis. Carried.

17. **Commitment Laws.** — General Counsel Peart stated that commitment laws as suggested by George G. Hunter should be reviewed and their introduction into the legislature considered.

Moved by Councilor Tanner, seconded by Councilor Phillips, that the commitment laws be reviewed and if previous supporters are still in favor thereof that they be introduced into the 1935 legislature. Carried.

18. **Collection of Fees in Judgment Cases.**—General Counsel Peart presented correspondence regarding proposed legislation governing the matter of collection of hospital and doctor bills after settlement of a claim of a minor against one causing personal injury to the minor for which the minor was admitted to the hospital, by amendment of Section 372 of the Code of Civil Procedure.

Moved by Councilor Ullmann, seconded by Councilor Rogers that legislation providing for collection of hospital and doctors' fees where judgments are rendered, be introduced at this legislative session. Carried.

19. **Francis vs. Nelson.**—General Counsel Peart reported on the present status of the case of Francis vs. Nelson, stating that he had advised the attorneys that it was impossible to correct or pass upon his brief until a transcript of testimony was received.

20. **Pacific Employees' Insurance Company vs. Insurance Commissioner.**—General Counsel Peart reported on the present status of the case of Pacific Employers Insurance Company vs. Insurance Commissioner Mitchell.

21. **Goodale vs. Brite.**—General Counsel Peart presented a report upon this case.

Moved by Councilor Ullmann, supported by Councilor DeLappe, that the County Hospital Bill as suggested by Counsel Peart, be introduced in the form as was finally amended in the 1933 legislature. Carried.

22. **Laboratory Bill.**—General Counsel Peart pursuant to instructions presented a proposed bill to govern clinical laboratories and suggested that the bill be introduced. Moved by Councilor Ullmann, seconded by Councilor Dukes, that the bill be introduced. Carried.

23. **Corporate Practice of Professions.** — General Counsel Peart presented proposed Anti-Corporate Practice Bills.

Moved by Councilor Ullmann, seconded by Editor Kress, that the bill be approved. Carried.

24. **Amendments to Medical Practice Act.**—Copies of proposed amendments to the Medical Practice Act contained in Doctor Pinkham's letter of January 16 were ordered sent to all councilors.

25. **Legislative Committees.**—Secretary presented a list of the committees appointed at the present legislative sessions.

26. **Board of Institutions.**—Letter regarding the Board of Institutions was read for the information of the Council.

27. **Clinic Bill.**—The ineffectiveness of the present Clinic Bill because of lack of funds for enforcement was discussed and it was suggested that an amendment be introduced increasing the licensing fee.

Moved by Councilor Kiger, seconded by Vice-President Peers, that the Clinic Law be amended to provide for effective control. Carried.

28. **Auditors Report—Budget.** — Chairman of the Auditing Committee Schaupp presented the Report of the Auditors on the funds and accounts of the Association.

Moved by Councilor Schaupp, seconded by Councilor Gibbons, that the Auditors' Report be approved.

A report on revision of printing costs of the JOURNAL was submitted and it was stated that a report would be submitted at the next meeting of the Executive Committee.

Moved by Councilor Ullmann, seconded by Chairman of Public Relations Dukes, that the budget report as submitted by the Executive Committee be received and placed on the docket for the next meeting of the Council.

29. **Advertising Contract.**—Doctor Wilson stated that he had contacted Mr. Guttman and it was agreeable to him to terminate the present advertising contract without awaiting for the six months' notice of termination period to elapse.

Moved by Editor Kress, seconded by Chairman of Public Relations Dukes, that the whole matter of arrangements for termination of Mr. Guttman's advertising contract be left in the hands of Doctor Wilson. Carried.

30. **Meeting of House of Delegates.**—Moved by Councilor Roblee, seconded by Councilor Phillips, that the following resolution be adopted:

WHEREAS, Pending and proposed federal and state legislation related to medical care and medical services makes it imperative for the California Medical Association to formulate principles and policies that will declare its position in regard to such legislation; therefore, be it

Resolved, That the Council of the California Medical Association under provisions stated in Article IX, Section 5, of the Constitution, direct the Association secretary to issue a call for a special meeting of the House of Delegates to convene at 1 p. m. on the second day of March, 1935, in the City of Los Angeles at the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, and be it

Resolved, That the object of such special meeting shall be:

(*a*) To receive and consider the report of the Committee of Five and to take such action thereon and to formulate such principles and policies in regard to health insurance medical services and medical care as the judgment and wisdom of the delegates may determine to be for the best interests of the public and the members of the Association;

(*b*) To transact such other business of the Association as may be transmitted to the House of Delegates by the Council of the Association; and be it

Resolved, That the order of business shall be as follows:

1. Call to order.
2. Report of Credentials Committee.
3. Roll call of delegates.
4. Reading of the call.
5. Report of the Committee of Five.
6. Council communications.
7. Resolutions.
8. Reference Committee, Report of.
9. Adjournment.

Unanimously carried.

31. **Conference With Interim Committee.**—Moved by Councilor Schaupp, seconded by Councilor Gibbons, that the representatives of the Council at the conference with the Senate Interim Committee, to be held in Sacramento, January 20, 1935, be the president, the president-elect, the speaker, the chairman of the Council, the secretary of the Committee of Five, and that Professor Dodd and General Counsel Peart be asked to accompany these representatives to Sacramento. Carried.

32. **Council Meeting.**—Moved by President Toland, seconded by Councilor Ullmann that the next meeting of the Council be held in the Los Angeles County Medical Association Building, Saturday, March 1, 1935, at 9 a. m. Carried.

33. **Adjournment.** — On motion of Councilor Gibbons, seconded by Councilor Kiger, the meeting adjourned at 5:15 p. m.

T. HENSHAW KELLY, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

Minutes of the Two Hundred and Twentieth Meeting of the Executive Committee of the California Medical Association

Held in the offices of the California Medical Association, Room 2004, 450 Sutter Street, San Francisco, Friday, January 18, 1935, at 4:30 p. m.

Present.—Clarence G. Toland, president; Robert A. Peers, president-elect; T. Henshaw Kelly, chairman of the Council; Edward M. Pallette, Speaker; Karl L. Schaupp, chairman of Executive Committee; Charles A. Dukes, chairman of Public Relations Committee; George H. Kress, editor; F. C. Warnshuis, secretary; Hartley F. Peart, general counsel.

Absent.—None.

1. **Call to Order.**—The meeting was called to order by the chairman of the committee, Karl L. Schaupp.

2. **Ivy Exhibit.**—Secretary reported on rental of store space at Sacramento for Ivy Exhibit.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that a special committee consisting of Doctors Peers and Schoff be authorized to make such arrangements as in their judgment they deem best, at a cost of not to exceed $100. Carried.

3. **Narcotic Committee.** — Secretary reported on meeting of Narcotic Committee on December 28, 1935, for which Chairman Kelly had appointed Doctors Catton and Warshuis to represent the California Medical Association.

Moved by Councilor Gibbons, seconded by President Toland that the membership of the Special Committee on Narcotic Problems be approved and that the committee be empowered to represent the Association at future conferences. Carried.

4. **Advertising Contract.**—Secretary reported on advertising contract of Mr. Guttman.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that the whole matter be left in the hands of Doctor Wilson. Carried.

5. **Advertising Commissions.** — Secretary reported on Association's policy of paying commissions when advertisement is inserted in JOURNAL in lieu of waiting until actual cash payment is made. Secretary also reported on uncollectible accounts now on books.

Moved by Editor Kress, seconded by chairman of Public Relations Dukes, that the recommendations of the secretary be approved and that no commissions be paid on advertising contracts until actual cash payment is received and that the secretary-treasurer be authorized to place "uncollectible accounts" in the hands of collection agencies and prepare a list of accounts where the institution of suits are recommended and that the latter accounts be submitted to the Council or Executive Committee for approval before final action is taken. Carried.

6. **Utah Medical Survey.** — Secretary presented the report of the Utah Medical Survey.

On motion of chairman of Public Relations Dukes, seconded by Councilor Kelly, the report was referred to the editor. Carried.

7. **SERA.**—Secretary reported that at present there was no SERA administrator and until such appointment was made matters would be at a standstill.

Doctors Peers and Toland were instructed to send correspondence regarding status of SERA to state secretary for insertion in the "Correspondence Column" with secretary's comments.

8. **Communication from San Francisco Society.**—A communication from the San Francisco County Medical Society regarding a dangerous drug was read by the secretary.

On motion of chairman of Public Relations Dukes, supported by Councilor Peers, the communication was referred to the Bureau of Pharmacy and Chemistry of the American Medical Association with request for information on legislation that may have been inaugurated in other states from a medical standpoint and from a legal standpoint, and that the secretary be requested to send copies thereof to the State Board of Health and submit a report to the Council or Executive Committee for further consideration and action. Carried.

9. **Disciplinary Procedure.**—Secretary presented letter from Doctor Molony regarding disciplinary procedure in constituent county societies. The secretary was instructed to reply to Doctor Molony.

10. **Unethical Advertising.** — Editor Kress brought up the question of unethical advertising as carried on by certain physicians and the need of legislation covering same, stating that this could be covered by an amendment to the Medical Practice Act.

11. **Auditor's Report.**—The secretary read the report of the Certified Public Accountants, Ernst & Ernst, on Association funds.

On motion of Kelly, seconded by Kress, the committee recommended that the Council adopt the Auditor's Report and pay the cost thereof. Carried.

It was ordered that the recommendations attached to the Auditor's Report be turned over to the Auditing Committee for study and report.

12. **Budget.**—Secretary read the proposed Budget of Receipts and Expenses for 1936, which was approved for consideration by the Council.

13. **Publication of Journal.**—Editor Kress and Secretary Warnshuis presented reports on publication costs of CALIFORNIA AND WESTERN MEDICINE.

Moved by Speaker Pallette, seconded by President-elect Peers, that a Committee of Three, consisting of the secretary, the chairman of the Council and the editor be requested to take this up with the James H. Barry Company and report back to the committee.

14. **X-Ray Acts.**—Various proposed x-ray bills were called to the attention of the committee and the general counsel reported that he would submit a tentative draft which would provide for control of clinical laboratories by State Board of Health.

15. **Adjournment.**—There being no further business the meeting adjourned.

KARL L. SCHAUPP, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

COMPONENT COUNTY MEDICAL SOCIETIES

CONTRA COSTA COUNTY

The regular monthly meeting of the Contra Costa County Medical Society was held on Tuesday evening, February 12, at the Nurses' Home of the County Hospital, Martinez.

The meeting was called to order by Dr. W. S. Lucas, who introduced Mr. T. H. DeLap of Richmond, Assemblyman to the State Legislature from this district. Mr. DeLap spoke most interestingly and informingly of the legislation pending before the State Senate and the State Assembly, with especial reference to those eighty bills which will have a bearing, either direct or indirect, upon the medical profession.

Doctor Lucas called upon Dr. E. W. Merrithew, who was chairman of the evening, to introduce Doctor Reynolds of San Francisco, who had graciously accepted the invitation to be speaker of the evening. Doctor Reynolds gave a splendid paper on the various manifestations of the *Endocrine Dyscrasias.*

Doctor Ford, as chairman of the Committee on Public Relations and Legislation, expressed his appreciation to Mr. DeLap, and sounded a word of warning that every member become legislation conscious.

Application for membership in the Society was presented by the secretary from Dr. Walter Taylor of Martinez. Motion that he be accepted was made by Doctor Weil, seconded by Doctor Sweetser, and carried.

Doctor Lucas announced the meeting place for the March meeting as Richmond, with Dr. J. B. Spalding as chairman; for April, in Richmond, with Dr. L. Abbott Hedges as chairman; and for May our custom-

ary dinner meeting at Pittsburg, with Doctors Kerns and Marks acting as committee in charge.

Doctor Beard presented some tentative figures of industrial fee schedule which might be incorporated in a possible fee schedule for part-pay patients. The matter was referred to Dr. Harry Ford, chairman of the Committee on Public Relations.

The attendance was gratifyingly large—twenty-six.

CLARA H. SPALDING, *Secretary.*

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of January 26 at St. Joseph's Hospital, Dr. Charles C. Falk, Jr., presiding. Twenty-four members and sixteen nurses were present.

The guests from San Francisco were Doctors R. C. Martin, Laurence Taussig, and Howard Morrow.

Committees were appointed on Program, Public Relations, Public Health, Legislation, Education, Membership, and Entertainment.

The main feature of the evening were the papers by the visitors—*Sinusitis, Etiology and Treatment* by Dr. R. C. Martin; *Ringworm and Athlete's Foot* by Dr. Laurence Taussig. Dr. Howard Morrow, in his jovial manner, gave us what he termed "easy," *Epithelium of the Mucous Membranes and Their Treatment.* Many slides were used in these discussions.

The Society and visitors received a great deal from these papers and expressed many thanks to the doctors for making the long trip.

LAWRENCE A. WING, *Secretary.*

KERN COUNTY

The regular January meeting of the Kern County Medical Society was held at the Padre Hotel, Thursday evening, the 17th.

With the approval of the board of directors, President Strongin appointed the following committees:

On Admissions — Doctors Gundry, Schaper, Moore. *On Professional Conduct* — Doctors Buchner, Packard, Moodie. *On Grievances* — Doctors Compton, Goodall William B. Smith. *On Programs* — Doctor Packard, Moore, McLain. *On Publications* — Doctors Compton, Garner, Cuneo. *On Hospitals and Dispensaries*—Doctors Root, Cuneo, Lange. *On History and Obituaries*—Doctors Veon, Buchner, Morris.

Following the business meeting Dr. F. M. Pottenger of Monrovia gave a talk on pulmonary tuberculosis, stressing particularly the importance of early diagnosis.

L. H. FOX, *Secretary.*

MENDOCINO COUNTY

The first regular meeting of the year of the Mendocino County Medical Society was held on February 14 at the Palace Hotel, in Ukiah. Dinner was served at 7 p. m. for members, their ladies, and guests. Members present were: Doctors Babcock, Bowman, Bennett, Cushman, Cleland, Hill, Hummel, Kirwin, Pinto, Le Baron, Toller, and Wrinkle. Guests present were: Doctors C. Abbott, G. K. Abbott, M. A. Craig, Lloyd Johnstone, Petty, and Starbuck.

After the dinner the meeting was called to order by Doctor Bowman.

The applications of Doctors Charles W. Leach of Kelseyville, Charles A. Craig of Lakeport, and G. K. Abbott of Ukiah for membership into the Society were read and accepted. A report of new bills before the legislature was read by Doctor Kirwin. Doctor Cushman reported on a purpose of the special meeting of the House of Delegates.

As this was the first regular meeting of the year, election of officers was held. Dr. R. B. Toller of Talmage was elected president; Dr. H. O. Cleland of Ukiah, alternate delegate; Dr. J. J. Kirwin of Ukiah, secretary-treasurer.

The next meeting will be held early in May in Lake County.

R. B. TOLLER.

ORANGE COUNTY

The regular monthly meeting of the Orange County Medical Association was held February 5 in the chapel of the Orange County Hospital, with our new president, Doctor Hawes, presiding.

After the customary business session the obituary of Dr. Clarence A. Neighbors was read.

Doctors F. J. Gobar of Fullerton and J. P. Boyd of Santa Ana, the latter a charter member of this Association, now in its forty-seventh year, were unanimously voted to honorary membership.

Dr. A. R. Roos of Loma Linda gave an enlightening and open-minded discussion and demonstration of *Bacteriophage in Septicemia.* Dr. Donald Abbott of the Orange County Hospital gave a concise history of the use of bacteriophage in septicemia due to Staphylococcus aureus, on one of the hospital doctors, with more than hoped-for results.

WALDO S. WEHRLY, *Secretary.*

SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, February 5. The meeting was opened by the President at 8 p. m. About sixty members and guests were present.

The following applications for membership were approved: Doctors E. A. Sommer, M. Antoinette Bennette, James W. Moreland, John Boyd Tyrrell, Mary E. Beall, Harry S. Blossom, Darrell E. Hayhurst and Pearl S. Waters, and Clement C. Counter by transfer from Orange County.

Dr. C. G. Hilliard, chairman of the SERA Medical Advisory Committee, explained that a difficulty had arisen at Twenty-nine Palms, in that Dr. W. A. Nicholson had done the CWA work for that area and now the SERA work, under the committee's impression that he was a physician. Recently an osteopath, Doctor Parker, also requested to do the work and when refused stated that Doctor Nicholson was an osteopath. The suggestion was made that it would be possible for the SERA workers in the Twenty-nine Palms district to be given extra work to pay these doctors directly and thus not conflict with the rules of the present medical program. Dr. F. E. Clough stated that the American Legion is endeavoring to have a physician at Twenty-nine Palms for the proper care of the people of that district, and that if and when a medical man was located there he could do the SERA work. It was moved and seconded that the plan suggested by Doctor Hilliard be used until such time as a medical man be located at Twenty-nine Palms. Passed.

Dr. C. G. Hilliard gave a short obituary on the late Doctors George Weger and E. J. Eytinge, following which, at Doctor Hilliard's suggestion, the whole Society stood in silence for a few seconds.

The secretary was asked to read the following resolutions, drawn up by a committee composed of Doctors Dole and Walton, to be spread upon the minutes of the Society, and a copy sent to the bereaved families.

IN MEMORIAM—ERNEST J. EYTINGE

WHEREAS, It has pleased the Almighty God to take from our midst our beloved and highly respected colleague, Dr. Ernest J. Eytinge; and

WHEREAS, This Society feels most deeply the loss of one who wisely guided its policies through many years of active development and progress; therefore be it

Resolved, That the San Bernardino County Medical Society extend to the bereaved family this expression of its deep sorrow and most sincere and heartfelt sympathy.

IN MEMORIAM—GEORGE S. WEGER

WHEREAS, It has pleased the Almighty God to take from our midst our beloved and highly respected colleague, Dr. George S. Weger; and

WHEREAS, This Society feels most deeply the loss of one who has been a member for many years; now therefore be it

Resolved, That the San Bernardino County Medical Society extend to the bereaved family this expression of its deep sorrow and most sincere and heartfelt sympathy.

* * *

The president read the following list of names—Doctors Dole, Gage, Hilliard, Hill, and Mock—which had been selected and approved by the Council to be sent to Supervisor Porch, from which he might choose a successor to the late Dr. E. J. Eytinge on the Medical Advisory Board to the County Hospital.

It was moved and seconded that the secretary send the above list of names to Mr. Porch. Passed.

The program of the evening was then given: *Case Report,* Dr. Walter Cherry; *Sickness Insurance,* Dr. Harry H. Wilson, president, Los Angeles County Medical Society; *Pending State Legislation Affecting Medicine,* Mr. Ben Read, secretary, Public Health League of California; *Modern Methods of Anesthesia* (motion pictures), Dr. A. D. Neubert.

A. E. VARDEN, *Secretary.*

SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the clubrooms of the Medico-Dental Building, Stockton, at 8:15 p. m. President C. A. Broaddus presided.

The regular meeting was preceded by a supper session held at the Hotel Clark at 6:15 o'clock, this supper being an innovation. It was very well attended, there being twenty-three persons, including four guests. A paper was presented at this meeting by Dr. A. L. Van Meter and Doctor Bawden, professor of chemistry, College of the Pacific, on *Medical and Chemical Tests for Inebriation.* This paper was accompanied by chemical demonstrations. It was very instructive and created considerable discussion.

The minutes of the preceding meeting and of two board of directors' meetings were read.

Dr. Dewey Powell gave a report on the coming meeting of the House of Delegates to be held in March.

The program for the evening was: *A Symposium on Bone Tumors.* Dr. C. S. Connor, professor of pathology, University of California, spoke on pathology. Dr. H. E. Ruggles, roentgenologist, University of California, spoke on the radiologic aspect of bone tumors, and Dr. E. I. Bartlett, associate professor of surgical pathology, University of California, spoke on the clinical and therapeutic aspect of these conditions. The papers were illustrated by means of lantern slides and pathological specimens. It was a very instructive presentation of the subject. The program was discussed by Doctors McGurk, Hull, Dozier, and C. V. Thompson, the discussion being closed by the guest speakers.

President Broaddus announced the next meeting would be *A Symposium on Tuberculosis.* He also announced there would be a board of directors meeting in the clubrooms at 5 p. m. Wednesday, February 13. He then brought up the subject of the University of California postgraduate session and the possibility of bringing this service to Stockton. Doctor Van Meter moved that a committee be appointed to investigate the establishment of this course at Stockton. This was seconded by J. P. Hull. The motion was carried.

The meeting was adjourned at 10:26 o'clock and refreshments were served.

G. H. ROHRBACHER, *Secretary.*

SAN LUIS OBISPO

REPORT OF THE SAN LUIS OBISPO COUNTY MEDICAL SOCIETY FOR THE YEAR 1934

President, Jens W. Larsen, Paso Robles.

Vice-President, L. T. Wade, San Luis Obispo.

Secretary-Treasurer, A. F. Gillihan, San Luis Obispo.

Speakers of interest provided constructive programs throughout the year. These included the following:

Dudley Smith of San Francisco—*Surgical Conditions of the Rectum and Colon.*

G. K. Rhodes and Fred H. Kruse of San Francisco—*Medical and Surgical Treatment of Peptic Ulcer.*

G. W. Pierce of San Francisco—*Burns and Their Treatment.*

Hugh Jones of Los Angeles—*Treatment of Fractures.*

Karl Meyer, Ph. D., San Francisco—*The Rise and Fall of Epidemics.*

Vern Hunt of Los Angeles—*Malignant Tumors of the Colon and Intestinal Obstruction.*

Sterling Bunnell of San Francisco—*Fractures of the Hip.*

Eric Larsen of Los Angeles—*Thyroid Disease: Differentiating between the Different Types.*

R. W. Langley of Los Angeles—*Thyroid in Heart Disease.*

Adolph Kutzmann of Los Angeles—*Lesions of the Urinary Tract.*

S. R. Mettier of San Francisco—*Classification of Anemias in General.*

E. Falconer of San Francisco—*Treatment of Secondary Anemias.*

A San Luis Obispo County branch of the Public Health League was organized in June and aided materially in defeating the proposed Chiropractic and Naturopathic measures in this county.

Speakers from the Society were provided for various clubs, bureaus and other organizations desiring ethical medical information on current topics.

The Society coöperated with the Parent-Teacher Association in securing more efficient treatment of the semi-indigents.

The officers elected for the year 1935 are as follows: President, C. J. Teass of San Luis Obispo; vice-president, G. D. Kelker of San Luis Obispo; secretary-treasurer, A. F. Gillihan of San Luis Obispo.

Preceding the election of new officers, a dinner and dance for the members of the Society, their wives, and guests was was held at the Hotel Paso Robles.

ALLEN F. GILLIHAN, *Secretary.*

SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara Medical Society was held in the Bissell Auditorium of the Cottage Hospital on February 11, with President Shelton presiding.

The minutes of the organization meeting of the Council were read and the recommendations contained therein were adopted and attached to the minutes as part of this meeting.

Doctor Gray then reported for the Committee on the Costs of Medical Care, and a proposed letter to Mr. Perkins of the Community Chest was read.

Upon balloting, Dr. George V. Hamilton was elected to active membership of the Society and Dr. George W. Jean was elected to retired membership.

The speaker of the evening, Dr. John C. Irwin of Los Angeles, was introduced by Doctor Shelton.

Doctor Irwin's paper on *Cesarean Section*, with motion pictures showing the various steps of the operation, was extremely interesting and instructive, and was discussed by Doctors Loveren, Johnson, and L. Eder.

WILLIAM H. EATON, *Secretary.*

SISKIYOU COUNTY

The meeting of the Siskiyou County Medical Society was held at the Yreka General Hospital, with Dr. J. R. U. Campbell presiding. The SERA work was discussed, and members are awaiting the uniform schedule to be drawn up before putting their names on the panel of that association.

The formation of a unit in the Auxiliary to the Society was discussed, as a means of stimulating more interest in the meetings. After the women have been consulted, it is hoped further steps will be taken.

The information that Doctor Warnshuis, our Association Secretary, might be paying us a visit was received with much pleasure. It is hoped that he will be in Weed on March 24 for our next meeting.

The Epstein Bill and other forms of health insurance without medical supervision were condemned.

As most of the snow has melted and the day was warm, the current meeting was poorly attended. One member even walked out on us to play golf.

LESLIE J. SEELEY, *Secretary.*

SOLANO COUNTY

The Solano County Medical Society held its regular monthly meeting on Tuesday, February 12. The meeting was well attended, there being about fifty present.

Dr. William Kerr of the University of California Hospital was the guest speaker of the evening, and his topic was *Coronary Vascular Disease.* The talk was exceptionally interesting. A. E. CHAPPELL, *Secretary.*

TULARE COUNTY

The first meeting of the Tulare County Medical Society for 1935 was held at Motley's Cafe, Sunday evening, January 27, at 6:30 o'clock. Dinner preceded the program.

The officers for 1935 formally assumed their rôles. Dr. Ray Rosson, president-elect, opened the meeting. The Society had as guests, Doctor DeLappe, councilor of the fourth district; Doctors D. G. Morton and H. G. Watson, speakers of the evening; Dr. Leonard Lipson, dentist; and Mr. Masterman, representing Meade Johnson. Dr. Ray Cronemiller of Exeter was introduced to the Society as an applicant for membership.

The financial report for 1934-1935 was reviewed and approved.

Doctor Zumwalt, Tulare County Health Officer, requested more accurate reporting of communicable diseases.

Doctor Fillmore asked that the Society devote a portion of its program to case reports and discussions. This matter was referred to the Committee on Education.

The following committees were appointed by Doctor Rosson to serve during 1935:

Committee on Physical Therapy — Edgar Brigham (chairman), J. C. McClure. *Committee on Education*— Frank Kohn (chairman), Philip S. Barber, Gilbert B. Furness, S. S. Ginsberg, W. B. Parkinson, K. F. Weiss. *Committee on Public Relations* — W. W. Tourtillott (chairman), Frank Guido, E. R. Zumwalt. *Committee on Membership*—A. W. Preston (chairman), H. G. Campbell, R. C. Hill, S. Rogers, N. Miller, P. Miller. *Committee on History and Obituaries*—Austin V. Miller (chairman), J. E. Beck. *Medical Milk Commission*— E. R. Zumwalt (chairman), Ray Cronemiller, Karl F. Weiss.

Doctor DeLappe submitted his report of the Council's activities for the past year. The coming California Medical Association meeting at Yosemite, May 13 to 16 inclusive, was brought to our attention. Health insurance plans are soon to be formulated, and our Society was urged to definitely instruct our delegate as to our attitude locally when the committee meets.

The educational program followed. Our first speaker was Dr. Daniel G. Morton of the University of California, who read a paper on *Breech Presentations.* The paper was clarified by lantern slides. Dr. H. G. Watson, obstetrician from San Francisco, next presented *An Outline of Prenatal and Postnatal Care in the Management of Normal Obstetrics.* A general discussion followed.

Though a rather lengthy meeting resulted, a majority of the members remained to see several films shown through the courtesy of Mr. F. A. Masterman, Mead Johnson & Company representative. One was on *Fertilization and Ovulation in the Female* and another, *Breech Extraction.*

The February meeting of the Tulare County Medical Society was held at Motley's Cafe Visalia, Sunday evening, February 17.

The Society had as guests, Doctors J. S. Glenn and Davis of Visalia, Doctors Winn and Smith of Springville, and Dr. C. W. Dodge, guest speaker of the evening.

A motion was made by Doctor Betts, seconded by Doctor Hill, to admit Dr. Ray Cronemiller to the Society. Doctor Cronemiller was elected by unanimous vote. An application for membership was also read from Doctor Winn of Springville.

It was with regret that we heard of Doctor Zumwalt's fractured arm.

Doctor Rosson introduced Dr. C. W. Dodge of the Veterans' Administration Facility, who is chief of the tuberculosis unit in San Francisco. His subject dealt with the United States Government's care of ex-service men with regard to medical care and hospitalization. His remarks were prefaced with an interesting historical account of military pensions from their inception to the present time. A number of questions regarding the care of veterans by the local doctors were answered. This talk helped considerably to clarify our ideas as to the nature of services rendered.

The remainder of the evening was devoted to a general discussion of the subject of health insurance. Dr. I. H. Betts, chairman of the Committee on Economics, reported the recommendations of his Committee on Health Insurance as follows: It was felt that some type of action is necessary if there is a change from the present system. In the event of organization of plans for a form of health insurance it is the committee's feeling that it be medically planned and controlled as far as possible; that medical monopolies should be prevented; that the plan should provide some regulation of qualification so that adequate medical attention can be offered and that compensation should be on a fee basis.

Members present expressed their opinions variously. A motion was made by Doctor Hill that our delegate be instructed to use his own discretion at the special meeting, keeping in mind the opinions as expressed here.

KARL F. WEISS, *Secretary.*

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the County Clinic Building on Tuesday, February 14, Doctor Strong presiding.

Members present were: Doctors Gronhovd, Coffey, Bardill, Welch, Sterling Clark, Armitstead, Illick, Felberbaum, C. Smolt, Shore, Mosher, and Morrison. Guests were: Dr. Nelson of Fillmore and Mr. Hollingsworth of Ventura.

The scientific portion of the program was presented first. This consisted of an interesting illustrated lecture on *Head Injuries and Their Treatment* by Dr. Dorrell G. Dickerson of Los Angeles, followed by a good discussion.

A short business meeting followed.

Dr. Lois Wyatt's application for membership in the Society was approved.

The State Secretary's letter pertaining to methods of stimulating interest in meetings was read.

Dr. Grundy Coffey reviewed the bills introduced during the present session of the legislature.

It was decided to devote the March meeting to a discussion of medical legislation and economics.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (67)

Contra Costa County.—Walter Taylor.

Los Angeles County—

Kenneth C. Brandenburg
Herman C. Bumpus
William W. Burbank
Paul Revere Burroughs
Vera R. Clough
George R. Diven
Burns R. Eastman
Ralph A. Ferguson
Charles V. Ganoe
William M. Heidenreich
Herman S. Hendrickson
E. Ross Jenney
W. T. Johnson
Albert W. Lindberg
Mary A. Manny
Ben D. Massey
William J. Matousek
A. M. McCarthey
Meyer Paretzky
Charles R. Parrish
Harry Poston
Edward K. Prigge
Louis J. Regan
Benjamin H. Sher
Isidor Singerman
Leonard W. Skelton
C. Richard Smith
C. E. Stafford
Ellis Stephens
Victor E. Thomas
C. C. Vardon.

Marin County.—Bernard M. Conroy, Alex Miller.

Orange County.—Willard C. DuBois.

Sacramento County.—Paul H. Guttman, Norris Jones, Clarence W. Kilcher.

San Bernardino County.—Charles N. Abbott, Walter A. Andrews, H. O. Beeson, H. Milford Nelson, Philip Savage, Jr., Edward A. Sommer.

San Diego County.—John Thorpe Wells.

San Francisco County.—Fred D. Fellows, Charles C. Fulmer, Paul A. Gliebe, Genevieve F. Gaffney, Lewis G. Jacobs, George W. Kulchar, Pearl M. Smith.

San Mateo County.—A. H. Shaghoian.

Santa Barbara County.—Gilbert V. Hamilton, C. S. Stone.

Santa Clara County.—Charles H. Breuer, Frederic Wallace Borden, Percy Perry Poliak, Harvey M. Slater.

Sonoma County.—James G. Anderson, Clement A. Stimson.

Tulare County.—R. E. Cronemiller.

Ventura County.—Gilbert O. Gronhovd, Robert Maxwell Jones.

Yuba-Sutter County.—Neal M. Loomis, Stanley R. Parkinson, Leon M. Swift.

Transferred (7)

Joseph B. Blackshaw, from Alameda County to Sonoma County.

Zach Coblentz, from Santa Barbara County to San Francisco County.

Clement E. Counter, from Orange County to San Bernardino County.

Bertrand S. Frohman, from San Francisco County to Los Angeles County.

Kathryn M. Kent, from Alameda County to Santa Clara County.

Orta E. Kuhn, from Alameda County to Napa County.

Alfred M. Tunnell, from Riverside County to Marin County.

Resigned (11)

Thomas Addis, from San Francisco County.
Wilbur Bailey, from San Francisco County.
F. L. A. Gonzales, from San Francisco County.
Charles F. Griffin, from San Francisco County.
W. H. Kellogg, from Alameda County.
W. H. Kelly, from Alameda County.
F. B. Mandeville, from Alameda County.
John L. Pasmore, from Alameda County.
W. Bruce Sargent, from San Francisco County.
Hester M. Sutherland, from Alameda County.
Lloyd E. Wilson, from San Francisco County.

In Memoriam

Adler, Howard Felix. Died at San Francisco, January 24, 1935, age 51. Graduate of Harvard University Medical School, Boston, 1908, and licensed in California the same year. Doctor Adler was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Campbell, Victor Emmanuel. Died at Fresno, November 28, 1934, age 32. Graduate of the University of Colorado School of Medicine, Denver, 1930, and licensed in California the same year. Doctor Campbell was a member of the Fresno County Medical Society, the California Medical Association, and the American Medical Association.

✝

Eytinge, Ernest Joseph. Died at Redlands, January 20, 1935, age 54. Graduate of the Columbia University College of Physicians and Surgeons, New York, 1904. Licensed in California in 1919. Doctor Eytinge was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

MacGowan, D. Granville. Died at Los Angeles, January 31, 1935, age 78. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1879. Licensed in California in 1886. Doctor MacGowan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Tucker, Heber Olney. Died at Santa Barbara, December 19, 1934, age 38. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1929, and licensed in California the same year. Doctor Tucker was a member of the Santa Barbara County Medical Society, the California Medical Association, and the American Medical Association.

✝

Weger, George Stephen. Died at Redlands, January 16, 1935, age 60. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1898. Licensed in California in 1923. Doctor Weger was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Medical Association.

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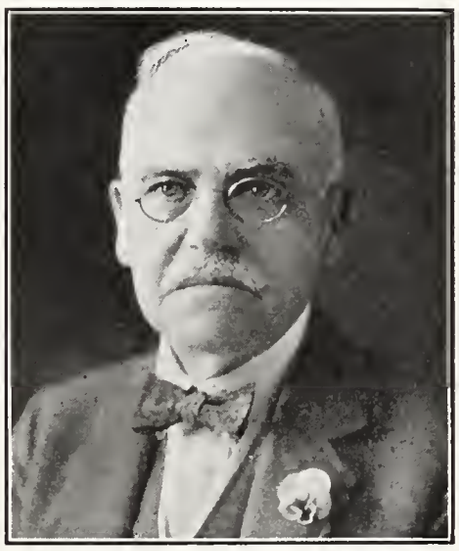
Weymann, Morie Frederick. Died at Los Angeles, January 13, 1935, age 35. Graduate of Washington School of Medicine, St. Louis, 1922. Licensed in Cali-

fornia in 1923. Doctor Weymann was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✠

Zussman, Samuel. Died at San Francisco, February 3, 1935, age 72. Graduate of the University of Strassburg, Germany, 1888. Licensed in California in 1891. Doctor Zussman was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

OBITUARIES



Davis Granville MacGowan
1857-1935

WHEREAS, Our beloved fellow member and colleague, Davis Granville MacGowan, has been called from his earthly labors; and

WHEREAS, During his half century of professional service, Doctor Granville MacGowan was identified with nearly all efforts having to do with the advancement of scientific and organized medicine; and

WHEREAS, As president and in other official capacities in the Los Angeles County and California Medical Associations, the Los Angeles County Hospital, the California Hospital, the School of Medicine of the University of Southern California, and other organizations and institutions, he carried out his responsibilities with great credit to himself, to the profession he loved, and to his fellow citizens; now therefore be it

Resolved, By the Board of Councilors of the Los Angeles County Medical Association that the sympathy of the members of this Association be extended to the bereaved family; and be it further

Resolved, That a copy of these resolutions be spread upon the minutes, that they be printed in the bulletin of the association, in the official journal of the California Medical Association, and a copy be sent to the family.

ROBERT V. DAY
GEORGE H. KRESS
WILLIAM DUFFIELD
JOSEPH M. KING
WILBUR B. PARKER
J. J. O'BRIEN

BIOGRAPHICAL SKETCH OF DAVIS GRANVILLE MAC GOWAN

Davis Granville MacGowan was born at Davenport, Iowa, April 12, 1857, of Colonial stock, his paternal ancestors coming to Georgia from Scotland with Oglethorpe. He attended the Millersville Normal School. He was a student at the University of Pennsylvania, receiving the M. D. degree in 1879. He took up postgraduate work at Berlin in 1880, in Vienna in 1882, and in Paris in 1883. Doctor MacGowan was an interne at the Blockley Hospital, Philadelphia in 1879; at the Charity Hospital of Berlin in 1880. Doctor MacGowan came to California in 1886, doing general practice from 1885 to 1890. His specialty since that time was genito-urinary surgery. During 1889 and 1892 he was the health officer of the City of Los Angeles. He held the chair of professor of dermatology and of genito-urinary diseases at the College of Medicine, University of Southern California from 1887 to 1909. For more than twenty-five years he was an attending genito-urinary surgeon at the Los Angeles County Hospital. He was an ex-president of the following medical associations: Los Angeles County Medical Association, Southern California Medical Society, and California Medical Association. He was a member of the American Urological Association, and Association Internationale d'Urologie.

✠



Ernest J. Eytinge
1880-1935

Dr. Ernest J. Eytinge of Redlands died in a few hours after injury in an automobile accident in Las Vegas, Nevada, on January 20, 1935.

Doctor Eytinge was born in New York City. He was graduated from the Columbia College of Physicians and Surgeons in 1904, and entered the United States Navy as surgeon on completion of his interneship. He served his country with honor and distinction for a period of fourteen years, after which he was retired with the rank of Lieutenant-Commander.

During his service he was stationed at Guam, where he became much interested in the treatment of leprosy; in Shanghai, where he undertook active operative work in the local hospital, and in various other foreign assignments.

On sick leave at the time of the entrance of the United States into the World War, Doctor Eytinge returned at once to active duty and did splendid service in the hospital at Mare Island and on convoy duty with the transports across the Atlantic.

On permanent retirement from the Navy at the conclusion of the war, he located in Redlands and practiced there from 1919 till his death.

Inspired by the highest ideals of the medical profession, an ardent patriot, a loving husband and devoted father, and with a keen sense of his civic and professional duties, the untimely passing of this brilliant surgeon brought great sorrow to all who knew him.

C. G. HILLIARD.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. PHILIP SCHUYLER DOANE President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

Auxiliary Convention Plans.—Our state president announces that the Auxiliary's plans for this year's convention in Yosemite, May 13 to 16, will be completed at the state board meeting on February 15 at Oakland. They will be printed in our pages here in the April issue. If you have not already sent for your reservations—news from the convention chairman, Mrs. Frederick N. Scatena of Sacramento, says they are fast being taken up—we hope you will soon do so and not miss this great gathering of the medical clans from every corner of our State.

Mrs. Doane sent a special invitation to the Auxiliary's national president, Mrs. Robert W. Tomlinson of Wilmington, Delaware, to be her personal guest at the 1935 California convention. It was with real regret that Mrs. Tomlinson wrote that she could not be with us. The press of responsibilities for the June conventions of the Auxiliary and of the American Medical Association meeting simultaneously in Atlantic City prevent her from taking time in May for the long journey from coast to coast.

* * *

New County Presidents.—December elections in some of the county organizations have brought changes in their officers and directors for the coming months. The following list of presidents for the twelve organized counties include the new presiding officers and are correct to May, 1935. State Auxiliary officers and the county presidents are listed each month on page 6 of the advertising section of CALIFORNIA AND WESTERN MEDICINE, and are given here simply to call your attention to the changes just made:

Alameda—Mrs. Robert T. Sutherland, Oakland.
Contra Costa—Mrs. M. L. Fernandez, Pinole.
Kern—Mrs. N. N. Brown, Bakersfield.
Los Angeles—Mrs. John V. Barrow, Los Angeles.
Mendocino—Mrs. Homer H. Wolfe, Fort Bragg.
Orange—Mrs. Harry G. Huffman, Santa Ana.
Riverside—Mrs. Hervey S. Faris, Riverside.
Sacramento — Mrs. Frederick N. Scatena, Sacramento.
San Diego—Mrs. Emil C. Black, San Diego.
San Joaquin—Mrs. George H. Sanderson, Stockton.
Santa Barbara—Mrs. John Van Paing, Santa Barbara.
Santa Clara—Mrs. C. Kelly Canelo, San Jose.

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News Notes from National.—Wilson County, Kansas, which is well organized medically, has an Auxiliary which has attained that ideal of membership for which we all strive—a 100 per cent quota of all the eligibles. Many of us thought it could never be done, but there it is. It can be done in Kansas.

In 1930 the Fulton County Medical Society of Georgia discussed the possibility of some day acquiring a new building, and the Auxiliary there straightway started an investment fund to run not less than five years and to be used in furnishing a room for the Auxiliary when the good day came. The doctors have just bought the ground for their building, and the Auxiliary fund, quite separate from their regular accounts, has reached the tidy sum of $853.

The Racine County Medical Auxiliary in Wisconsin has been making a study of the various county and city institutions, and to date has visited several types of hospitals, including the Isolation Hospital, County Farm and Asylum, the County Sanitarium, the Southern Wisconsin Colony of Feeble-minded and Epileptics, as well as going to the City Filtration Plant.

The Woman's Auxiliary to the Oregon State Medical Society took an intensive interest and an active part in the fight against a proposed amendment to the state constitution which would have nullified the Basic Science Law passed by the 1933 legislature. For eight months before the election the Auxiliary took this measure and made it an educational issue, building their entire program around it and sending out information on the questions involved. The Oregon Auxiliary deserves no small praise for their part in the campaign which ended in a defeat by more than 115,000 majority of this amendment which could only be construed as a step backward.

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County Auxiliary Reports

Alameda County.—The January meeting of the Woman's Auxiliary to the Alameda County Medical Association was held on the 18th at the Women's Athletic Club in Oakland. Hostesses for the lunch were Mrs. Clarence B. Hills, assisted by Mrs. Leonard Barnard and her committee. Besides the regular business session there were songs by Miss Evelyn Fiegenberg and an address by Dr. B. W. Black, Medical Director of County Institutions, upon his field of work. The latter part of the afternoon was given over to cards for those who enjoyed playing.

* * *

Contra Costa County.— The Contra Costa County Auxiliary had an interesting meeting at the Mount Diablo Country Club. It was held in the central part of the county, to be easily accessible to all the doctors' wives, the object being a membership drive and a welcome home for our president, Mrs. M. L. Fernandez, returning home from a four months' African cruise. She gave a very interesting and vivid description of a trip from Johannesburg to Victoria Falls, telling of the different tribes, the mode of travel, the scenery, and the animal life. It was greatly enjoyed by everyone present.

Mrs. Thomas J. Clark, president-elect of the State Auxiliary, spoke on *Reasons for an Auxiliary.* Mrs. T. Hanna of the County Federated Women's Clubs spoke on their project, *Medium-Priced Hospitalization for the Great Middle Class.* In compliance with a letter from the State Auxiliary to hold the annual election of officers in May of this year, it was decided to hold over the present officers until that time. There were seven prospective members present and a delegation from the Alameda County Auxiliary, which included Mesdames Thomas J. Clark, Robert T. Sutherland, A. A. Alexander, Louis Dyke, and Harold Trimble. The meeting of our neighbors and the non-member doctors' wives of the county with our Auxiliary members will mean a closer bond of friendship and a larger Auxiliary.

MRS S. N. WEIL, *Secretary.*

* * *

Los Angeles County.—As a delightful departure from the usual custom of meeting at a central point in Los Angeles, the Glendale section entertained the Woman's Auxiliary of the County Medical Association at the Oakmont Country Club on January 22,

*As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

Mrs. W. O. Leach acting as chairman in charge, with Mrs. Harry V. Brown as program chairman and Mrs. John B. Barrow, president, presiding. Following the luncheon, attended by about two hundred, the guests were entertained by Miss Mary Hobson, contralto, who sang a group of songs accompanied by Mr. W. E. Strowbridge, and by Mrs. Norman Whytock, who gave readings from the poems of Milne and of Edna St. Vincent Millay. The meeting then moved into the lounge, and Dr. Orrie Ghrist, recently returned from the South Seas, gave a talk illustrated with moving pictures, describing his trip, which exceeded in interest and ability the powers of the "Globetrotter," himself. Doctor Ghrist gave a comprehensive description of these islands as to position, geological formation, animal life, ethnology, architecture, and native dances. He explained the high increase in the incidence of tuberculosis among the natives by the influence of the missionary who insisted on the islanders wearing garments, which in rainy weather constituted a wet swathe on bodies unused to covering. The technique of making tapa cloth was also interestingly described. Altogether it was one of the most delightful talks we have heard, and it is the wish of the Auxiliary that Dr. and Mrs. Ghrist will take another trip and bring their experiences to us again.

As a result of interest on the part of about twenty-five Auxiliary members, Mrs. Charles E. Futch, with the assistance of Mrs. James F. Percy, has organized a class for the study of parliamentary procedure. The class is conducted by Elizabeth G. McKelvey, author of the "Ritual of Parliamentary Law for Ordinary Assemblies," and will consist of ten sessions of one hour each devoted to study and practice. The first meeting was held the hour preceding the luncheon at Glendale, and will be held regularly just before the main meeting of each month.

The Pasadena members of the county held a membership tea on January 29 at the home of Mrs. Rollan W. Kraft on Midlothian Drive in Altadena. Mrs. Harry Markoff, Mrs. George Dock and others of the Pasadena group assisted. Mrs. Philip Schuyler Doane, the state president, presided and presented Mrs. John V. Barrow, county president, who gave a short talk on the purposes and activities of the Auxiliary. Mr. Charles Arthur, Pasadena City Bacteriologist, spoke on the history of immunization, and was followed by Dr. Wilton L. Halverson, Pasadena City Health Officer, who gave a concise and vivid talk illustrated by slides depicting graphs of the decreasing incidence and mortality rate of diphtheria. Pasadena upholds its reputation as a model city in regard to one use to which its birth certificates are put. A year after a recorded birth a letter is sent to the parents by the Health Department suggesting immunization against diphtheria for the child, to be done either by the family physician or pediatrician in charge. Three or four pertinent facts on immunization are given in the letter by way of information.

Music by a string trio and delicious refreshments added to the pleasantness of the afternoon.

Mrs. Harold E. Crowe,
Corresponding Secretary.

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Orange County.—At the February meeting on Tuesday the 5th, the Orange County Medical Auxiliary assembled at the home of Mrs. G. E. Raitt on North Ross Street in Santa Ana and heard an address by Dr. K. H. Sutherland on *Immunization.* He contrasted present-day conditions with those preceding the discovery of the smallpox vaccine in the eighteenth century and explained immunization for diphtheria, scarlet fever, whooping-cough, and typhoid. A short business session was in charge of the county president, Mrs. Harry Huffman. Refreshments were served from a lace-covered table brightened with yellow and orange appointments, at which Mrs. Hiram Currey and Mrs. K. H. Sutherland poured. Co-hostesses with Mrs. Raitt were Mesdames D. R. Ball, M. W. Hollingsworth, and John McAuley.

Elizabeth M. Sutherland, *Secretary.*

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Sacramento County. — The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. W. R. Briggs on Tuesday evening, January 15, with the president, Mrs. J. Howard Hall, presiding. The first business was the election of officers for the ensuing year. Mrs. C. B. Jones, who had been nominated as a director, stated that she found it impossible to serve this year, so Mrs. E. O. Brown was nominated from the floor to serve in her stead. With this exception the ticket as published last month was voted upon, and unanimously carried. The treasurer, Mrs. T. Binkley, reported seventy-seven paid-up members on January 1, 1935. Mrs. Hall then turned the meeting over to the new president, Mrs. Frederick N. Scatena. A rising vote of thanks was given Mrs. J. Howard Hall for the splendid year just passed under her leadership.

The two speakers of the evening, Dr. E. T. Rulison and Dr. C. B. McKee, were introduced. They proceeded to show lantern slides, illustrating their recent trip to European clinics, and to speak of the chief points of interest in their trip. The program gave the members much pleasure. At the conclusion of the address Mrs. Briggs, assisted by Mesdames A. M. Henderson, C. B. Jones, D. Schuyler Pulford, E. C. Turner, and Frank Krull, served delicious refreshments from a beautifully decorated tea table. The next meeting will be held at the home of Mrs. William K. Lindsay.

Sarah L. Brendel, *Secretary.*

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Santa Barbara County.—The Auxiliary to the Santa Barbara County Medical Society met on Friday, January 4, at the home of Mrs. Horace F. Pierce. Thirteen members were present. A discussion of the advantages to be gained by changing the time of the election of officers to correspond with that of the State Auxiliary was introduced, and it was decided to change the by-laws so that the annual election would be held in May. It was also decided to fix the date for the regular meeting on the first Monday of each month.

Dr. R. C. Main of the Santa Barbara County Health Department and Dr. W. H. Eaton of the Santa Barbara City Health Department presented their views on the proposed county-wide health plan and gave a detailed and comprehensive survey of the present workings of their respective departments. Doctor Eaton maintained there is no remediable overlapping in the present three-unit system, holding that distances are too great for a satisfactory consolidation in the county. He believes that each community or unit to be better prepared to gauge its budget needs and to know its particular problems than would a board of supervisors, even though they were chosen to represent their own community. Doctor Main believes there is costly overlapping of facilities and in duties of officials and in duplication of records. The County Health Department at present has three headquarters—Santa Maria, Lompoc, and Santa Barbara—besides a separate set-up for the city of Santa Barbara and for its schools. Doctor Main stated that the one-unit county-wide health plan has been worked out at the request of the Santa Barbara City Council. This plan provides for the addition of experts in the field of public health and that, compared with the present three-unit plan, it would reduce the costs to Santa Barbara by $18,860.

Tea was served at the conclusion of these interesting talks, with Mrs. A. Q. Spaulding and Mrs. W. R. Hunt assisting Mrs. Pierce with the pouring.

Mrs. W. Remfry Hunt, *Secretary.*

NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D.... Associate Editor for Nevada

E. E. HAMER, Carson City President
R. O. SCHOFIELD, Boulder City.....President-Elect
C. E. SECOR, Elko.....First Vice-President
HARRY W. SAWYER, Fallon.....Second Vice-President
HORACE J. BROWN, Reno.....Secretary-Treasurer

COMPONENT COUNTY MEDICAL SOCIETIES

WASHOE COUNTY

The Washoe County Medical Society had its regular monthly meeting Tuesday evening, February 12, at the State Building. After hearing the minutes read, the president asked if the Medico-Legal Committee was ready to report. In the absence of Doctor Brown, chairman, Doctor DaCosta made a tentative report and was instructed by the president that as soon as he was able to complete a report a called meeting of the Society would be held to act upon the report. There being no further business to be discussed, the president called upon the guest speaker of the evening, Dr. William G. Patton, former superintendent of the St. Louis County Hospital. Doctor Patton's address was on the epidemic of encephalitis, which occurred in St. Louis in the summer of 1933. The following is a résumé:

"The first patient that appeared at the St. Louis County Hospital was a negro, who was admitted on July 23, 1933, and tentatively diagnosed as tubercular meningitis. During the course of his illness a white woman was admitted with precisely the same symptoms and the additional history that her husband had been recently discharged from a sanitarium, where he had been treated for tuberculosis. The first patient showed marked rigidity of his neck and pathologic toe signs were present; positive Kernig's. He also had evidence of pulmonary tuberculosis in his left chest which was quite marked and extensive. There was evidence of myocarditis with valvular lesion. Lumbar puncture was done and fluid was under increased pressure, cell count was 180, 70 per cent of which were lymphocytes. With the above history, diagnosis of tubercular meningitis was made. However, tuberculosis bacillus was not found in the spinal cord fluid. The day before the first patient died, a third patient, a woman, was admitted with precisely the same picture and a diagnosis made of encephalitis. We then realized we were in the midst of an epidemic of encephalitis, and during the next two days ten to twelve additional cases were admitted. The first patient admitted was the only case that showed lethargic symptoms. All other cases appeared as typical meningitis symptoms, showing marked irritability and maniacal symptoms and frequently had to be restrained.

"Chief complaint: Severe headache for several days previous, increasing in severity, with no relief from all sorts of treatment. Coincident with headache, increase of temperature from 101 to 108 degrees. Generalized aches and pains throughout the whole body. Occasional nausea and vomiting. Slight to marked rigidity of neck. One or two cases showed double vision. Occasionally a lethargic condition appeared.

"As cases progressed they became delirious, irrational and unconscious, occasionally showing loss of sphincter control with incontinence.

"Examination revealed: Tremor of tongue, very dry. Tremor of hands and arms. Pupils equal and reacted to light actively. Pulse, 80 to 100; respiration, 18 to 30; pronounced neck rigidity; positive Kernig sign. Catatonic symptoms appeared occasionally. Absence of abdominal reflex. Superficial reflexes, active or hyperactive. Hypersensitive to touch and pressure to parts of body, especially the extremities. Positive Babinski, positive Chaddock, positive Gordon, positive Oppenheim.

"Spinal fluid showed: Increased pressure. Clear and colorless. Globulin positive. Sugar increased. Cell count ranged from 1,200 to 1,400. Negative to cultures.

"Blood findings: Twelve thousand to twenty-five thousand leukocytes. Schilling test showed, J. 8 and stabs and bands 23; segments, 58. Lymphocytes, 11 or more.

"Blood picture: Highly infectious, with a pronounced shift to the left. Disease affected mostly the ages between forty and sixty. Few, if any, children suffered from the disease. Only in one or two instances other persons in families contracted the disease. Patients usually died within ten days or recovered. The maniacal type predominated and few lethargic types were seen. After one year, with periodic examinations every three months, no after-effects showed from the disease. Filterable virus apparent cause of disease. Mosquitos, after experimentation, proved not to be the contributory cause or carrier. Disease not related to vesicular stomatitis, equine-encephalomyelitis, acute poliomyelitis, or Japanese encephalitis. Disease did resemble the Australian epidemic. Reports indicate successful transmission of a virus, isolated from cases of encephalitis of the St. Louis epidemic, to monkeys and mice. Swiss mice are more susceptible and cheaper. More fatal to persons suffering from degenerative diseases. Horse and man, different strains.

"Pathology: Marked edema of the brain. Capillary hemorrhages seen throughout cortex of brain, kidney and spleen.

"Treatment: Repeated puncture of the spinal column to aid severe headache, otherwise treatment symptomatic. Adrenalin given in five-drop doses, subcutaneous every four hours, in a number of cases performed almost a miracle and the patient recovered. Adrenalin, however, should be stopped when the patient shows marked restlessness and irritability.

"Patients were discharged from the hospital at the end of ten days or two weeks, when symptoms had subsided.

"In the beginning, all cases were isolated, but later, due to the great number developing the disease, they were placed in wards in the General Hospital, without any material effect on persons coming in contact with them. Few, if any, doctors or nurses became infected while administering to the infected patients.

"In the city of St. Louis, 507 cases were reported with 132 deaths; St. Louis County reported 537 cases and 92 deaths; outstate, 1 case with 1 death. All cases were isolated as soon as reported to health authorities.

"The Metropolitan Health Council was composed of the Health Commissioner of St. Louis, health commissioners of various municipalities of St. Louis County, the superintendent of the Isolation Hospital of St. Louis, the superintendent of St. Louis County Hospital, and the Hospital Commissioner of St. Louis. Other physicians and public health workers were also invited.

"The purpose of the Council was: (a) To coördinate all public health activities in the metropolitan area for the handling of emergency; (b) to adopt uniform rules and regulations as far as possible for handling cases of contagious and infectious diseases; (c) to adopt uniform rules and regulations for isolation and quarantine.

"A central laboratory was established where all blood and spinal fluids were sent for examination. Pathologists connected with the central laboratory were notified when post-mortems were being performed at the various hospitals so they might attend all cases of encephalitis.

"No doubt the prompt diagnosis and isolation materially reduced the total number of cases and assisted in checking the epidemic."

THOMAS W. BATH, *Secretary.*

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

California Medical Association, Yosemite National Park, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

Medical Broadcasts*

American Medical Association Health Talks.—The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, central standard time.

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San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of March is as follows:

Tuesday, March 5—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: The Value of Animal Experimentation to Medical Science.
Tuesday, March 12—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Reasons for Periodic Health Examination.
Tuesday, March 19—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Overweight—A Liability.
Tuesday, March 26—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: In Case of Accident.

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Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of March is as follows:

Saturday, March 2—KFI, 9 a. m. Subject: The New Frontier.
Saturday, March 2—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, March 5—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, March 9—KFI, 9 a. m. Subject: The New Frontier.
Saturday, March 9—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, March 12—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, March 16—KFI, 9 a. m. Subject: The New Frontier.
Saturday, March 16—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, March 19—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, March 23—KFI, 9 a. m. Subject: The New Frontier.
Saturday, March 23—KFAC, 10 a. m. Subject: Your Doctor and You.
Tuesday, March 26—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, March 30—KFI, 9 a. m. Subject: The New Frontier.
Saturday, March 30—KFAC, 10 a. m. Subject: Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Physicians' Income Tax for 1935.—The American Medical Association Bureau of Legal Medicine and Legislation, on page 403 of the February 2 issue of *The Journal of the American Medical Association* prints its annual survey of the federal income tax requirements. The article discusses the income tax in relation to physicians, and is an excellent summary of the subject.

California Tuberculosis Association.—The 1935 annual meeting of the California Tuberculosis Association will be held in Long Beach, March 26 to 30. An extensive program has been arranged, the scientific papers being presented through clinical and sociological sections of the association. A large number of physicians and social welfare workers who are interested in tuberculosis work are included among the speakers.

All who are interested in copies of the detailed program may obtain further information by writing to the chairman of the Program Committee, Dr. Philip H. Pierson, or to the executive secretary of the association, Mr. William F. Higby, 45 Second Street, San Francisco.

Seventh International Congress on Industrial Accidents and Diseases.—The Seventh International Congress on Industrial Accidents and Diseases will be held at Brussels, Belgium, from July 22 to 27, 1935. The American Committee of the Congress is under the chairmanship of Dr. Fred H. Albee of New York for the Section on Accidents, and that of Dr. Emery R. Hayhurst of Columbus, Ohio, for Industrial Diseases.

The American delegation to the congress will sail from New York on August 8 and visit London, Amsterdam, The Hague and Paris and, optionally, Budapest. Physicians interested in the congress or in the medical tour in conjunction with it may address the secretary, Dr. Richard Kovacs, 1100 Park Avenue, New York.

American Urological Association.—On Tuesday, Wednesday and Thursday, June 24 to 29, 1935, from 9 a. m. to 5 p. m., scientific sessions of the American Urological Association will be held in the Gold Ballroom of the Palace Hotel, San Francisco. On Wednesday the Ramon Guiteras lecture will be delivered by Dr. Hugh H. Young, professor of urology, Johns Hopkins University. On Friday the sessions of the Western Branch Society, American Urological Association will be held. On Saturday the Association will be the guests of the Oakland urologists. There will be operative and dry clinics at the Highland Hospital. In the afternoon there will be a boat ride on the Bay for the purpose of inspecting the sites of the bridges. From the standpoint of entertainment, on Monday, June 24, a golf tournament to be held at Lakeside Golf Club. Monday night, June 24, will feature a stag banquet at the Lakeside Golf Clubhouse. On Wednesday night the banquet of the American Urological Association will take place, and on Thursday night there will be a dinner dance. Both of these events will be held at the Palace Hotel.

All urologists who are members of the California Medical Association and who are interested, are invited to attend the scientific sessions as guests. Further information may be had by writing to Dr. Miley B. Wesson, San Francisco.

The American Society of Tropical Medicine.—At the thirtieth annual meeting of the American Society of Tropical Medicine, held in San Antonio, Texas, in November, 1934, the following officers were elected: President, Edward B. Vedder of Washington, D. C.; president-elect, Henry E. Meleney of Nashville, Tenn.; vice-president, Lewis W. Hackett of New York, N. Y.; editor, Charles F. Craig of New Orleans, La.; secretary-treasurer, Alfred C. Reed of San Francisco. This brings the secretaryship of the society to the University of California and is a recognition of the importance of tropical medicine, centering in the University of California and the Pacific Coast.

Press Report of American Medical Association Special Session of House of Delegates.—In one of the other departments of this issue the report of the American Medical Association House of Delegates is printed in full (see page 207). The "Associated Press" sent out the following report to the newspapers on its circuit:

Forced Sickness Insurance Opposed at Assembly of National Association.—The American Medical Association recently reiterated its vigorous opposition to compulsory sickness-insurance plans being studied by the President's Committee on Economic Security.

But it tempered its stand by approving projects for setting up a system of voluntary illness insurance on a community basis.

Decrying what it termed attempts to regiment the profession in proposed legislation and attacking certain sections of the Wagner Bill embodying the National Administration's social security program, the Association's House of Delegates adopted a declaration of policy for its one hundred thousand member physicians.

The report, carried unanimously at the second extraordinary session in the organization's history, set forth:

"The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the governments of the individual states or by any individual, industry, community or similar body."

A Motion-Picture Film for Mothers.—In order to educate mothers who are about to assume the responsibility of the care of the newborn, a film has been produced. The care and feeding of infants as it should be done in the average home, as well as advice for the mother's own health, is shown in detail.

The film was produced by the department of obstetrics and gynecology of the University of Southern California at Los Angeles, under the personal direction of Doctors Lyle G. McNeile and Donald G. Tollefson, in coöperation with the producers of Carnation Milk.

It is a 35-millimeter film in three reels, requiring about thirty-five minutes to show, and was made to replace or amplify the present nurses' demonstration as given in hospitals for mothers who are about to leave the hospital. The film was shown at the Hall of Science at the Century of Progress in Chicago during the closing week of the Fair, and was enthusiastically approved by all who viewed it.

The film may be loaned without charge for an indefinite time to any ethical hospital in which, at least, fifty confinements occur each month. The film must be shown at least twice a week and a report of the number of showings, as well as the number of persons who viewed the film, must be forwarded once a month.

At the California Hospital at Los Angeles the film is shown three times a week in the Solarium of the obstetrical floor for the mothers. It was also found advisable to show the film once a week in the evenings for the relatives of the maternity patients as well as the practical nurses who are to assist in the care after returning from the hospital.

Further information may be obtained by writing to Dr. Donald G. Tollefson, 511 South Bonnie Brae Street, Los Angeles.

Membership Certificates.—Have you framed yours for display in your office? If not, do so today and so give publicity to your county society. Patients are often recommended to only consult society members.

Postgraduate Course on Neuropsychiatry at the Menninger Clinic, Topeka.—A postgraduate clinic in neuropsychiatry in general practice will be held at the Menninger Clinic, Topeka, April 15 to 20, inclusive. Lectures, case studies, and seminars included in the five and a half-day course will be exclusively directed to the application of modern neuropsychiatric principles to the cases which the general practitioner frequently sees in this field.

The course will be given by the members of the staff of the Menninger Clinic, with the assistance of Doctors W. McK. Craig and Henry Woltman of the Mayo Clinic, and Dr. Titus H. Harris of the University of Texas Medical School.

Los Angeles County Hospital Clinical Conferences. On March 28 and 29 an important clinical session will be held in Los Angeles, under the auspices of the Clinical and Statistical Section of the Los Angeles County Medical Association.

Clinics will be held at the Los Angeles County Hospital.

The Clinical and Statistical Section of the Los Angeles County Medical Association, realizing the desire of the general profession for postgraduate clinics, has made it possible to utilize the material available at the Los Angeles General Hospital. The attendance and interest shown by the general profession will be the deciding factor as to the establishment of clinics held at regular intervals in the future, thus making the clinical material at the County Hospital available to the profession at large.

Clinical lectures will be given constantly during two days in the two auditoriums of the County Hospital by various members of the staff. Each subject will be complete in itself. There will be no general discussions, but opportunity will be afforded those who are particularly interested in the topics discussed to visit the wards or departments of the hospital and see demonstrations of patients. Here questions may be asked and discussions entered into with members of the staff.

All members of the California Medical Association and visiting members of other state associations are most cordially invited to attend these clinics and demonstrations.

There are no registration or other fees required.

The details of the various papers and clinics on the program follow:

CLINICS AT LOS ANGELES COUNTY HOSPITAL

Thursday, March 28

AUDITORIUM

Obstetrics

Lyle McNeile, Chairman

9:00 to 10:30 a. m.
Complications of Pregnancy: Diabetes, Cardiac, Hyperthyroid, Tuberculosis—D. G. Tollefson.
Toxemias of Pregnancy—Lyle G. McNeile.
Indications of Operative Interference.—E. M. Lazard.
After which, conferences in the wards.

NURSES CLASSROOM

Orthopedics

John C. Wilson, Chairman

9:00 to 10:30 a. m.
Fractures of the Hip—Alfred E. Gallant.
Skeletal Traction—John Dunlop.
Fractures of the Elbow—John C. Wilson.
After which, conferences in the wards.

Urology

Robert V. Day, Chairman

9:00 to 9:40 a. m.
Ureteral Calculi—Harry M. Martin.
9:45 to 10:30 a. m.
Renal Tuberculosis—J. C. Negley.

Urology Staff Room

10:30 to 11:10 a. m.
Prostatic Obstructions—Robert V. Day.
11:15 to 12:00
Bladder Tumors—J. J. Crane.

Surgery

Clarence G. Toland, Chairman

10:30 a. m. to 12:00
Minor Surgery—Paul McMasters.
Plastic Surgery—W. S. Kiskadden.
Chest Surgery—H. E. Schiffbauer.
Ward conferences.

Contagious Diseases

Paul Hamilton, Chairman

10:30 a. m. to 12:00
Scarlet Fever—O. Halverson.
Poliomyelitis—A. G. Bowers.
Technique of Handling Contagious Diseases—Robert Meals.
Whooping Cough—M. Tobias.
Ward conferences.
Buffet lunch.

Gynecology

Rafe C. Chaffin, Chairman

1:30 to 3:00 p. m.
Cancer of Cervix—Wilburn Smith.
Pelvic Relaxation—Henry Shaw.
Pelvic Inflammations—Homer Seaver.
Ward conferences.

Cardiology

B. O. Raulston, Chairman

1:30 to 3:00 p. m.
The Hypertensive Heart—Verne Mason.
Acute Coronary Thrombosis—M. H. Leake.
Cardiac Irregularities—Manning Clark.
Chronic Rheumatic Endocarditis—Richard Ware.
Ward conferences.

Internal Medicine

F. M. Pottenger, Chairman

3:00 to 4:30 p. m.
Hemoptysis—Carl Howson.
Artificial Pneumothorax—E. W. Hayes.
Acute Respiratory Infections—Roy E. Thomas.
Abdominal Ascites—John C. Ruddock.
Ward conferences.

Allergy

3:00 to 4:30 p. m.
Asthma; Hay Fever; Allergic Skin Manifestations—R. W. Lamson.
Ward conferences.

Cautery Surgery

Continuous demonstrations will be held throughout the day by James F. Percy and staff.

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Friday, March 29

AUDITORIUM

Internal Medicine

John V. Barrow, Chairman

9:00 to 10:00 a. m.
Pernicious Anemia—H. P. Hare.
Cardiorenal Syndrome—Harry H. Wilson.
Diabetes—Howard West.
Ward conferences.

NURSES CLASSROOM

Eye, Ear, Nose, and Throat

George H. Kress, Chairman

9:00 to 10:30 a. m.
Hypertrophied Tonsils and Adenoids in Children—Acute Middle Ear—Frank Detling.
Cancer of Larynx—Simon Jesberg.
Syphilis and the Eye—M. M. Beigelman.
Glaucoma—L. A. J. La Motte.
Ward conferences.

FOURTH FLOOR

Urology

9:00 to 9:40 a. m.
Renal Tuberculosis—A. A. Kutzmann.
9:45 to 10:30 a. m.
Ureteral Calculi-Transurethral Removed—W. B. Parker.

Urology Staff Room

10:30 to 11:10 a. m.
Bladder Tumors—Paul A. Ferrier.
11:12 a. m. to 12:00
Prostatic Obstruction—H. C. Bumpus.

General Surgery

Charles E. Phillips, Chairman

10:30 a. m. to 12:00
Appendicitis—Charles Sturgeon.
Intestinal Obstruction, with X-Ray Demonstrations—George Thompson, X-Ray Department.
Ward conferences.

Pediatrics

Oscar Reiss, Chairman

10:30 a. m. to 12:00
Rheumatic Heart and Allied Conditions—Philip Rothman.
Vitamin Deficiencies, Rickets, Scurvy—Earl Moody.
Upper Respiratory Infections—Oscar Reiss.
Ward conferences.
Buffet lunch.

Internal Medicine

Madison T. Keeney, Chairman

1:30 to 3:00 p. m.
Common Skin Diseases—E. D. Lovejoy.
Syphilis: Secondary Stage—Stanley Chambers.
Wards: C. N. S. Lues; Samuel D. Ingham.
Wards: Psychoses—Martin G. Carter and associates.

Symposium

Roy A. Carter, Chairman

1:30 to 3:00 p. m.
Gastro-Intestinal Lesions:
X-Ray Department.
Surgery Department.

General Surgery

W. H. Kiger, Chairman

3:00 to 4:30 p. m.
Hemorrhoids—Williams Daniels.
Fissure—A. J. Murrietta.
Fistula in Ano—E. J. Clemons.
Breast Tumor—C. J. Rowan.
Head Injuries—Carl Rank, G. H. Patterson, L. J. Adelstein, R. B. Raney.

Symposium on Uremia

Newton Evans, Chairman

3:00 to 4:30 p. m.
Uremia—Medical Department, Harry H. Wilson; Obstetrical Staff; Urological Staff; Neurological Staff.
Demonstration of pathological material.

* * *

Buffet Supper and Entertainment, 6:30 p. m.

County Medical Building, 1925 Wilshire Boulevard
With a "Road Show," under the direction of D. G. Tollefson.

CORRESPONDENCE

Concerning collection agency standards — A communication from the California Association of Collection Agencies:

March 1, 1935.

To the Editor:—Although the California Association of Collection Agencies has truly made remarkable progress in sponsoring and fostering a high standard of business ethics, its officers are fully aware that only "bachelors' wives and old maids' children are always perfect." As Diogenes said, "To arrive at perfection, one should have sincere friends, or inveterate enemies; because he would be made sensible of his good or ill conduct either by the censures of one or the admonitions of the other."

In an endeavor to be of service to the medical fraternity, and in an ambition to correct and discipline those in our ranks who may carelessly, or otherwise, commit errors that are contrary to public welfare, we earnestly ask that our attitude be brought to the attention of physicians and that they, in turn, notify our Association of any untoward practices on the part of collection agents.

Our Association has just recently adopted a revised code. Among other important advancements, a rule is now in order making it incumbent for agents to furnish clients with monthly accountings whether they are insisted upon or not. This particular rule was initiated by the majority of our members to discourage contracts with buried clauses that often made for dissatisfaction on the subject of remittances. No Association member can now maintain his membership and violate this rule. Eventually, when the law is revised, no collection agency can be licensed unless it makes monthly accounting a practice.

As you are probably aware, the California Association of Collection Agencies sponsored the present laws wherein all collection agencies are now licensed by and bonded to the State, and are under direct supervision of the State Superintendent of Collection Agencies. In addition, if the medical fraternity will coöperate by reporting unethical or unsatisfactory actions on the part of collection agents, the Association will lend its assistance to the State authorities in effecting corrections.

Respectfully,

California Association of Collection Agencies.
By Louis Spencer, President.
Income Securities Building, Oakland.

Concerning "Tuberculosis Subsidy" Assembly Bills 1927 and 1928:

To the Editor:—I enclose herewith a copy of a resolution presented to the Trudeau Society of Los Angeles at its regular meeting Tuesday February 26.

Very truly,
Carl R. Howson, M. D.

* * *

RESOLUTION

Whereas, For the past twenty years there have been paid to the counties (or cities) of the State of California from State funds a subsidy of $3 per week for every indigent patient cared for in a tuberculosis ward or hospital by said counties; and

Whereas, There have been introduced into the California Legislature two bills, A. 1927 and A. 1928, which have for their purpose the removal of the present legal requirement that such tuberculosis wards or hospitals shall conform to the regulations of, and be approved by, the State Bureau of Tuberculosis before such State aid shall be forthcoming; and

Whereas, During the twenty years of its existence it has been conclusively demonstrated that the enforcement of this requirement has been the most important single factor in the improvement of the provision for and the treatment of these patients throughout the State, and the attainment of the present high standards for their care; and

Whereas, The removal of this restriction will not only increase the payments from the State treasury, but will also open the way for possible serious abuses; now therefore be it

Resolved, That the Trudeau Society of Los Angeles is of the opinion that the passage of these bills would inevitably tend to lower the quality of care given these unfortunate sick, and would render further improvements in their care in public institutions extremely difficult; and be it further

Resolved, That we request our representatives in the Assembly and Senate to vigorously oppose the passage of these bills.

Concerning article in February issue:

To the Editor:—Referring to the paper on "Pharyngo-Esophageal Diverticulum, Pulsion Type" by Doctor Ziegelman, on pages 85 to 90 of the February, 1935, issue, he quotes a letter by Lord Moynihan.

There is an error in the quotation of Moynihan's letter as published in *Surgery, Gynecology and Obstetrics,* page 128 of the January, 1932, issue, in reference to the Laimer-Haeckermann area. To quote Lord Moynihan correctly would be as follows:

"It is Laimer, who was prosector at Graz, and Haeckermann, now of Bremen, in whom interest centers. The 'point' to which Doctor McEvers refers is not a point, but an area. The 'Lainer-Hackermann point' becomes, therefore, the 'Laimer-Haeckermann area.' "

It is true that these two names have been misspelled in the literature and also in the medical dictionaries. In The American Illustrated Medical Dictionary (Dorland), thirteenth edition, published in 1925, the names are given as "Lannier-Hackerman area."

To correct the spelling of these names, they become *Laimer* and *Haeckermann.*

I am writing only to call attention to the incorrect spelling of the names of both *Laimer* and *Haeckermann.*

A. E. McEvers, M. D.
1930 Wilshire Boulevard, Los Angeles.

Concerning Pan-American Medical Association cruise to Rio Janeiro:

To the Editor:—Enclosed find a news item concerning the Pan-American Medical Association which I am asking you to publish in California and Western Medicine. You must realize the importance of this great Pan-American movement. The officials of the parent organization as well as myself will appreciate your publishing this.

Very sincerely yours,
Charles P. Mathé, M. D.

* * *

"The Pan-American Medical Association, which embraces the leading physicians and surgeons of the Western Hemisphere, will meet in New York to board the steamship *Columbia* of the Panama Pacific Line. The 40,000-ton luxury liner, the largest ever to cruise to South America, is being redecorated, and could accommodate one thousand passengers in the atmosphere of a smart beach club. . . .

The ship will sail from New York on July 18, returning to New York on August 28. The itinerary will be as follows: New York, Havana, Curacao, five days at Rio de Janeiro (where a scientific congress will be held), three days at Santos (for attending a scientific convention at Sao Paulo), returning via Trinidad, Santo Domingo, Kingston (Jamaica), Havana, and New York.

During the voyage scientific meetings in all branches of medicine will be conducted. This will give an excellent opportunity for physicians, while enjoying an ideal summer holiday, to meet with and hear lectures by the leaders of the profession in all sections of surgery and medicine.

The Brazilian Government has suggested August for the congress there, as this is the time of the year that the climate is most delightful. His Excellency, Dr. Getulio Vargas, President of the Republic of Brazil, has expressed his pleasure at the selection of Rio de Janeiro and Sao Paulo for the congress and the opportunity his country will have of being the host to the members of the Pan-American Medical Association. . . .

Apart from deriving definite scientific advantages from the cruise, the medical men will establish social contacts of lasting value to Pan-American relations and visit Rio de Janeiro, known as the most beautiful of all cities, with its famous Oswaldo Cruz Institute of Tropical Medicine; Santos, with its bathing beaches at the height of the season; Sao Paulo, with its world-renowned University and Instituto Sero-Therapeutico for the study of reptiles and poisons.

An inaugural dinner officially announcing the plans will be given by the Pan-American Medical Association on March 1 on board the steamship *Columbia* in honor of His Excellency, Dr. Oswaldo Aranha, Brazilian Ambassador to the United States.

Previous congresses of this association have been held in Havana (1929), Panama City (1930), Mexico, D. F. (1931), Dallas (1933). Last year a "floating congress," similar to the coming congress, was held in which 560 physicians, their families and friends took a cruise, visiting Cuba, Colombia, Venezuela, Panama, and Puerto Rico. The scientific meeting at Maracay, Venezuela, and the hospitality of His Excellency, General Juan Vicente Gomez, President of the Republic of Venezuela, were important features of last year's congress. . . .

Thomas Cook and Son will be general managers of the cruise. The prices will range from $450 for the forty-day cruise.

For further information, write to Pan-American Medical Association, 745 Fifth Avenue, New York City."

SERA IN LOS ANGELES COUNTY

A Summary of the Program Being Put Into Effect for the Medical Care of the Unemployed by the L. A. C. R. A., Coöperating with the Los Angeles County Medical Association.

Provisions for the medical care of the unemployed in Los Angeles County have been made.

The importance of this movement, in which State and Federal funds shall pay for medical services to be rendered to a considerable portion of our citizenry, should be appreciated by every physician.

In Los Angeles County, the Los Angeles County Relief Administration (L. A. C. R. A.) coöperating with the County Medical Association, will administer this emergency program under the supervision of the SERA (State Emergency Relief Administration).

Louis Boonshaft, M. D., has been appointed medical director of this service, with offices at 741 South Flower Street.

On February 6, to help expedite the formation of a panel of physicians and surgeons, the Los Angeles

County Medical Association sent out a letter and a return post card to the physicians and surgeons of Los Angeles County. The letter stated briefly what the program was. The post card was included to allow the profession of Los Angeles County to register for membership on this panel.

Complete details have not as yet been worked out, but generally this medical care will be administered as follows:

All those individuals in Los Angeles County who are entitled to relief under the State Emergency Relief program will be entitled to medical care.

For convenience Los Angeles County is divided into some twenty-odd unemployment districts. Each of these districts, under the supervision of the L. A. C. R. A., will have a social service unit. Each of these units will be supplied with a panel of doctors in that district. When an unemployed resident of that district is found to be in need of medical care he will be given an authorization certificate which he will take to his family physician, if he has one, or to another physician whom he may choose from the panel in that district.

This first certificate authorizes the physician to make his examination and diagnosis and render immediate treatment, either at his office or at the patient's home, according to the nature of the case. On this certificate the physician will make his recommendations for further treatment if it is indicated; these recommendations to be approved by the Medical Advisory Committee of three doctors of medicine in that district, selected by the County Medical Association and approved by the L. A. C. R. A.

Each member of the panel will receive from the L. A. C. R. A. special prescription pads. All prescriptions will be written in triplicate, one to be retained by the doctor, and two to be given to the patient. The patient will have these prescriptions filled at one of the several drug stores in that district that have arranged with the L. A. C. R. A. for this prescription work.

Doctor Boonshaft is preparing the various forms necessary to carry out this program. When they are completed a complete set of forms, together with a letter, explanatory of the whole system, will be mailed to each physician who has signified his willingness to become a member of the panel.

The offices of the Los Angeles County Medical Association have been beseiged with telephone and mail inquiries asking questions about details. Most of these questions will be answered when the forms to be used are mailed to members of the panel of the L. A. C. R. A.

At the present time funds are available for medical care, but not for hospitalization. It is anticipated that funds for hospitalization will be available shortly.

The fees allowed at present are $1.25 for an office call and $1.75 for a home call.

No physician will be compensated for his services unless the unemployed patient brings proper authorization, with the exception possibly of night emergency calls. On such calls the doctor will be paid for his services if the call has been made on one who is found to be entitled to this service.

Methods of providing special medical care at this writing have not been worked out. Panel members will be informed of such details as they are perfected.

* * *

The letter which was sent to the members of the Los Angeles County Medical Association pursuant to the above, follows:

LOS ANGELES COUNTY MEDICAL ASSOCIATION
Los Angeles

February 6, 1935.

IMPORTANT! L. A. C. R. A. PANEL

To All Duly Licensed and Practicing Physicians and Surgeons in Los Angeles County:

The Los Angeles County Medical Association has been charged with the responsibility of offering to all duly licensed and practicing physicians and surgeons in Los Angeles County the opportunity to become members of the panel being created for the medical care of the unemployed and their families under jurisdiction of the State Emergency Relief Administration.

Cases deserving of such care will be sent to their family physician if they have one in their unemployment district. If they have no such family physician, a physician on the district panel may be selected. These cases will carry authorization from the L. A. C. R. A. for such medical service.

The fees allowed are $1.25 for an office call, and $1.75 for a home visit. More complete information on fees and detailed methods of procedure will be sent to those physicians and surgeons who wish to accept a place on this panel.

The attached post card should be filled out completely and mailed immediately by all those who wish to take part in this work.

E. VINCENT ASKEY, M. D.,
Secretary.

FEDERAL NARCOTIC FARM

The first United States Narcotic Farm, near Lexington, Kentucky, will open for the reception of admissions on or about May 1. It will accommodate a maximum of one thousand persons and is designed to accommodate males only. Its object and purposes are to rehabilitate, restore to health and train to be self-supporting and self-reliant those who are admitted thereto. The control, management and discipline are to be maintained for the safekeeping of the individual and the protection of the community. Experiments are to be carried on to determine the best methods of treatment and research in this field, and the results disseminated to the medical profession and the general public, to the end that states may make some provision for establishing a similar policy for helping to solve the problem of drug addiction. The function of the institution at Lexington, therefore, assumes the character of a treatment and research center, and of an educational and rehabilitation center with certain custodial features superimposed.

Heretofore, as far as public policies are concerned, drug addiction has been regarded solely as a penal and correctional problem without cognizance being taken of its medical, sociological or economic significance. The institution is to be administered by the United States Public Health Service. As a matter of convenience to Fellows of the American Medical Association, there is herewith printed the regulations governing admissions to that institution. . . .

* * *

The above was the opening paragraph of an article which was printed on page 574 of the February 16, 1935, issue of *The Journal of the American Medical Association.* Editorial comment in the same issue (page 566) was as follows:

Narcotic Farms—A Public Policy

Elsewhere in this issue appear the regulations governing the admission of persons to the federal narcotic farms, the first of which is being established at Lexington, Kentucky. Addiction to habit-forming drugs is widespread throughout the United States. All classes and groups of the general population are affected by such addiction in one way or another. The geographic distribution of these people corresponds relatively to the geographic distribution and density of the population; occupation, age periods of life, nativity, sex, color, and marital or educational status are not exempting factors. Thus, addiction to narcotic drugs resembles an endemic disease, for it is through and on the people. Based on knowledge available, it is estimated that there are about one hundred thousand drug addicts in the United States.

Perhaps there is no condition in which man is placed that is fully comparable with that of opium addiction, in which food, shelter, raiment, and all those things "by which men live" are cheerfully abandoned for the drug of choice. Contact and association with others who are addicted to the use of such drugs stand out as the more prominent and frequent immediate causes of addiction. The removal of addicts from American

communities is, therefore, a step in the direction of preventing further addiction.

The authorization and establishment of facilities for the confinement and treatment of persons addicted to habit-forming drugs bears a direct relationship to policies respecting enforcement of antinarcotic laws and the protection of the American community. Problems in penal and correctional procedure, the uses of narcotic drugs in medical practice, research and the quest for more accurate and fundamental knowledge concerning the nature of drug addiction and related phenomena will be studied to better advantage under the conditions prevailing when the new government institutions begin to function. Moreover, these farms are a response to the instinctive demands ever present in the American people that the sick and afflicted shall be set in the way of strength and hope.

PROPOSED PUBLIC HEALTH LEGISLATION*

A List of Bills Submitted to the California Legislature Now in Session, and Having Relationship to the Public Health

I

SENATE BILLS

Senate Bill 19, by Slater (referred to Committee on Criminal Law and Procedure). Relating to procedure when defendant in a criminal case claims insanity as a defense.

Senate Bill 21, by Slater (referred to Committee on Public Health and Quarantine). An act to regulate the production and distribution of serums, vaccines, bacterial cultures and viruses, to provide for the licensing of persons manufacturing, preparing and distributing the same, and to provide penalties for violation.

Senate Bill 77, by Mixter (referred to Committee on Public Health and Quarantine). Relating to agreements between counties and deposits of funds in connection with establishment and maintenance of tuberculosis hospitals.

Senate Bill 98, by Slater (referred to Committee on Public Health and Quarantine). Providing for licensing of persons who perform diagnostic tests on material from persons suffering from infectious or contagious disease and providing penalties for violations.

Senate Bill 111, by Gordon (referred to Committee on Hospitals and Asylums). Making an appropriation for major construction and equipment at Napa State Hospital.

Senate Bill 154, by Williams (referred to Committee on Public Health and Quarantine). Amending Medical Practice Act to require a bond of $250 in cases of appeal from judgment of the Board in revoking, suspending or placing on probation of the holder of any certificate. The bond to secure payment of the cost of appeal in case such appeal be decided against the defendant.

Adding to "Unprofessional Conduct" the following:

"The fraudulent representation by advertisement or otherwise that a manifestly incurable condition of sickness, disease, deformity, ailment or injury of any person can be cured.

"Advertising to cure or attempt to cure, or treat any person or persons for syphilis, for prostate conditions or prostatic ailments.

"The making or signing by the holder of a certificate issued under the provisions of this or any prior medical practice act of any false certificate in his professional capacity and/or while acting within the scope of practice permitted by the certificate issued to him.

"Accepting employment from persons, firms or corporations who directly or indirectly solicit same."

Senate Bill 155, by Williams (referred to Committee on Public Health and Quarantine). Relating to courses of study required of applicants for certification under the State Medical Practice Act. Also requiring that senior, fourth or final year be completed in an approved medical school in the United States, or in lieu thereof has served at least one year in residence in a hospital approved by the board for interneship located in the United States.

Senate Bill 225, by Young (referred to Committee on Prisons and Reformatories)—Skeleton bill. Providing for institution or farm for drug addicts.

Senate Bill 229, by Young (referred to Committee on Revision of Criminal Law and Procedure). Amending State Narcotic Act. Strikes out word "habitual" and makes it unlawful to administer, furnish or prescribe for "a user."

Senate Bill 263, by Young (referred to Committee on Public Health and Quarantine)—Skeleton bill. Amending Poison Act, relating to narcotics.

Senate Bill 264, by Young (referred to Committee on Public Health and Quarantine)—Skeleton bill. Similar to No. 263.

Senate Bill 305, by Difani (referred to Committee on Finance). An act to provide for the reimbursement of hospitals for expenditures incurred in the emergency care and treatment of indigent persons injured in motor vehicle accidents. Skeleton bill.

Senate Bill 311, by McColl (referred to Committee on Public Health and Quarantine)—Companion bill to No. 309.

Senate Bill 390, by Tickle (referred to Committee on Public Health and Quarantine)—Skeleton bill. An act to provide for the establishment and administration of a system of health insurance.

Senate Bill 391, by Tickle (referred to Committee on Public Health and Quarantine)—Companion bill to No. 391. An act to provide for the establishment, regulation and supervision of systems of health service insurance in California.

Senate Bill 392, by Parkman (referred to Committee on Public Health and Quarantine). Relating to the conduct of clinical laboratories and the licensing of clinical laboratory technologists for the purpose of protecting the public health and defining a clinical laboratory and a clinical laboratory technologist, and providing penalties for violation.

Senate Bill 417, by McCormack (referred to Committee on Governmental Efficiency). Authorizing a nursing survey to be made by the University of California.

Senate Bill 454, by Williams, Tickle and Difani (referred to Committee on Public Health and Quarantine)—Skeleton bill. To provide for establishment and administration of a system of health insurance for persons in certain income groups.

Senate Bill 468, by Williams (referred to Committee on Public Health and Quarantine). Relates to violations of Medical Practice Act. Provides for injunctions.

Senate Bill 471, by Difani (referred to Committee on Insurance). Relating to Medical and Hospital Service Insurers.

Senate Bill 472, by Difani (referred to Committee on Insurance). Relating to proceedings against insolvent insurers.

Senate Bill 473, by Difani (referred to Committee on Insurance). Adds a new section to the Insurance Code relating to Medical and Hospital Insurance.

Senate Bill 474, by Difani (referred to Committee on Insurance). Adds a new chapter to the Insurance Code relating to Medical and Hospital Service Insurers.

Senate Bill 491, by Snyder (also 492, 493, 494) (referred to Committee on Insurance). All relating to Compensation Insurance.

Senate Bill 499, by McGovern (referred to Committee on Public Health and Quarantine). Relating to penalties for violation of Dental Act Injunction Bill.

Senate Bill 512, by Swing (referred to Committee on Public Health and Quarantine). Amends Pharmacy Act.

Senate Bill 534, by Perry (referred to Committee on Hospitals and Asylums). An act relating to persons in private psychopathic institutions.

Senate Bills 627 and 628, both by Perry (referred to Committee on Judiciary). Relating to insane or incompetent persons.

Senate Bill 662, by Jesperson (referred to Committee on Revision of Criminal Laws and Procedure). Relating to cruelty to animals.

Senate Bill 709, by Difani (referred to Committee on Governmental Efficiency). An act creating a State Board of Eugenics.

Senate Bill 760, by Young (referred to Committee on Criminal Laws and Procedure). Amends Narcotic Act relating to Institutions for Drug Addicts.

Senate Bill 824, by Edwards (referred to Committee on County Government). Relating to powers of Boards of Supervisors.

Senate Bill 831, by Pierovich (referred to Committee on Judiciary). Amends Compensation Act.

Senate Bill 831, by Seawell (referred to Committee on Insurance). Amends Compensation Act.

Senate Bill 862, by Difani (referred to Committee on Military Affairs). Relating to exemption of soldiers and sailors from license fees for itinerant vendors of drugs—nostrum ointments or appliances sold for the cure of disease, injuries or deformities.

Senate Bill 895, by Difani (referred to Committee on Insurance). Relates to life and disability insurance.

Senate Bill 905, by Difani (referred to Committee on Insurance). Relates to miscellaneous casualty insurance.

Senate Bill 995, by Fletcher (referred to Committee on Revenue and Taxation). An act to amend Retail Sales Tax Act relating to exemption of hospitals from payment of tax.

Senate Bill 1035, by Jesperson by request (referred to Committee on Public Health and Quarantine). Amends Dental Practice Act relative to examining and licensing of persons who have been engaged as apprentices.

Senate Bill 1056, by Bigger (referred to Committee on Governmental Efficiency). Relating to registration of births.

II

ASSEMBLY BILLS

Assembly Bill 58, by Gilmore (referred to Committee on Public Health and Quarantine). Relating to meat inspection.

Assembly Bill 59, by Jones (referred to Committee on Public Health and Quarantine). Providing for formation and operation of garbage disposal districts.

Assembly Bill 67, by Geyer (referred to Committee on Public Health and Quarantine). Referring to sale of "cold storage eggs."

* This list received from Mr. Ben Read, executive secretary of the Public Health League of California.

Assembly Bill 99, by Peyser (referred to Committee on Judiciary). Requires persons bringing actions for damages for personal injuries to submit to an examination of their persons by "a competent physician or physicians, surgeon or surgeons."

Assembly Bill 101, by Boyle (referred to Committee on Judiciary). Adds to property exempt from execution or attachment: "one motor vehicle not exceeding $1,000 in value used by a physician, or surgeon, in the legitimate practice of his profession."

Assembly Bill 172, by H. J. Evans (referred to Committee on Public Health and Quarantine). Referring to "cold storage eggs."

Assembly Bill 173, by H. J. Evans (referred to Committee on Public Health and Quarantine). Referring to "cold storage eggs."

Assembly Bill 188, by Boyle (referred to Committee on Medical and Dental Laws). Relates to advertising food, drink, drug or cosmetic products by radio broadcasting and providing penalties for violation.

Assembly Bill 195, by Gilmore (referred to Committee on Public Health and Quarantine). Relating to meat inspection.

Assembly Bill 235, by Breed (referred to Committee on Social Service and Welfare). Permits county supervisors to secure care for indigent sick and dependent poor in "any hospital maintained and operated by any county or by the state or by any state college, university or other institution supported in whole or in part by taxation, or by any persons, firms or corporation in the county or city and county."

Assembly Bill 236, by Breed (referred to Committee on County Government).

Assembly Bill 246, by Cronin (referred to Committee on Medical and Dental Laws). An act for the regulation and control of corporations organized for the purpose of operating nonprofit hospital service plans.

Assembly Bill 254, by Cottrell (referred to Committee on Judiciary). Relating to reports of medical examinations and expert medical testimony in civil actions and proceedings.

Assembly Bill 255, by Cottrell (referred to Committee on Judiciary). Providing for selection of impartial expert medical witnesses and impartial medical examiners appointed by the court, from eligible lists or panels to be provided under the direction of the Civil Service Commission.

Assembly Bill 270, by Wright (referred to Committee on Governmental Efficiency and Economy). Establishes a Board of Institutions consisting of seven members appointed by the Governor. The Board to appoint the Director of Institutions and consult with him and furnish advice in regard to all questions of general policy as to the conduct of the department.

Assembly Bill 287, by Fulcher, Thorp and Eicke (referred to Committee on Social Service and Welfare). Permits county supervisors to secure care for indigents in hospitals "within or without the county or city and county."

Assembly Bill 390, by Crowley (referred to Committee on Judiciary). Relating to birth certificates in adoption cases.

Assembly Bill 393, by Fisher (referred to Committee on Judiciary). Permits commitment of insane persons or inebriates to private institutions.

Assembly Bill 429, by Donnelly (referred to Committee on Education). Requires schools to provide first medical aid equipment.

Assembly Bill 493, by Thorp (referred to Committee on Live Stock and Dairies). Relating to milk inspection.

Assembly Bill 498, by Thorp (referred to Committee on Live Stock and Dairies). Relating to milk inspection.

Assembly Bill 504, by Donihue (referred to Committee on Motor Vehicles). Requires Motor Vehicle Department to establish emergency first aid stations along the highways.

Assembly Bill 542, by Jones (referred to Committee on County Government). Permits cities and towns to contract with county health departments for services of such departments.

Assembly Bill 543, by Jones (referred to Committee on County Government)—Skeleton bill. Companion bill to No. 542.

Assembly Bill 551, by Fisher (referred to Committee on Judiciary). Relates to maternity hospitals or homes.

Assembly Bill 564, by Cronin, and *Assembly Bill 565*, by Cronin (referred to Committee on Public Health and Quarantine)—Skelcton bill. Amending Narcotic Act.

Assembly Bill 603, by Richie, Reaves, Rosenthal, Stream, Wallace, Pelletier, McCarthy, Flint, Lore, Miller and Morgan (referred to Committee on Social Service and Welfare). Provides that "in any county where a county hospital has been established, any expectant mother, regardless of the length of her residence in the county, who is unable to pay for her necessary care, must be admitted to such county hospital.

Assembly Bill 616, by Miss Miller (referred to Committee on Public Charities and Corrections)—Skeleton bill. Provides for institution or farm for drug addicts.

Assembly Bill 674, by Lyon (referred to Committee on Public Health and Quarantine). Establishing "Registered Sanitarians" under authority of Board of Public Health.

Assembly Bill 690, by Gilmore (referred to Committee on Insurance). An act to define life, and accident and health insurance on the assessment plan and to provide for the formation of corporations to conduct such insurance.

Assembly Bill 701, by Redwine (referred to Committee on Judiciary)—Skeleton bill. Relating to expense of maintenance in state hospitals of persons charged with crime.

Assembly Bill 760, by Peyser by request (referred to Committee on Public Health and Quarantine). An act to provide for local health districts in any part of the state and defining their powers and duties.

Assembly Bill 784, by Boyle (referred to Committee on Public Health and Quarantine). An act relating to the sale, disposition of, advertising, and control through licensing, of prophylactics and contraceptives.

Assembly Bill 785, by Boyle (referred to Committee on Medical and Dental Laws). Relating to hours of employees selling drugs and medicine.

Assembly Bill 786, by Lore (referred to Committee on County Government). Relates to powers of Boards of Supervisors.

Assembly Bill 791, by Pelletier (referred to Committee on Insurance). An act to provide for the establishing of unemployment and social insurance.

Assembly Bill 819, by Lyon (referred to Committee on Judiciary). Amends law referring to commitment of insane persons.

Assembly Bill 867, by Patterson (referred to Committee on Insurance)—Skeleton bill. An act relating to health insurance.

Assembly Bill 890, by Fisher (referred to Committee on Medical and Dental Laws). Amends Medical Practice Act relating to Chiropodists.

Assembly Bill 912, by Miller (referred to Committee on Public Health and Quarantine). Amends Cosmetology Act.

Assembly Bill 946, by Reaves (referred to Committee on Public Health and Quarantine). Chiropractic Act.

Assembly Bill 954, by Kallam (referred to Committee on Hospitals and Asylums). County Hospital Act defining indigent sick, etc.

Assembly Bill 970, by Corwin (referred to Committee on Conservation). Improvements at Pacific Colony and State Narcotic Hospital.

Assembly Bill 990, by Cronin (referred to Committee on Medical and Dental Laws). Amending Dental Act relating to advertising.

Assembly Bill 992, by Cronin (referred to Committee on Medical and Dental Laws). Amends Dental Act relative to diagnosis.

Assembly Bill 998, by Boyle (referred to Committee on Education). Relating to average daily attendance in schools in connection with pupils excused to visit dentists.

Assembly Bill 1009, by Nielsen (referred to Committee on Medical and Dental Laws). Amends Clinic Act to fix fee at $20.

Assembly Bill 1010, by Gilmore (referred to Committee on Public Health and Quarantine). Cannery inspection.

Assembly Bill 1022, by Cunningham (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

Assembly Bill 1023, by McMurray (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

Assembly Bill 1037, by Peyser (referred to Committee on Medical and Dental Laws). Regulating use of x-rays on living persons.

Assembly Bill 1046, by Richie (referred to Committee on Medical and Dental Laws). An act to authorize and permit physicians, surgeons, medical doctors, osteopaths, chiropractors and any other practitioners who have been duly licensed to practice similar professions under the laws of California, to enter into any contracts or agreements with their patients for professional services or hospitalization without complying with the provisions of law applicable to insurance and insurance contracts.

Assembly Bill 1076, by Hunt (referred to Committee on Medical and Dental Laws)—Skeleton bill. Dental Act.

Assembly Bills 1096 and 1097, by Anderson (referred to Committee on Social Service and Welfare). To provide for establishment and administration of systems of health insurance.

Assembly Bill 1139, by Cunningham (referred to Committee on County Government). Relating to emergency aid for sick and injured.

Assembly Bill 1140, by Cunningham (referred to Committee on Judiciary). Relating to apprehension of insane persons and the issuance of warrants therefor and relating to the duties of court commissioners.

Assembly Bill 1202, by Cottrell (referred to Committee on Judiciary). Relating to duty of hospitals, pharmacies, physicians and other persons to report cases of persons suffering from wounds and injuries.

Assembly Bills 1212-1213-1214-1215, by Lyon (referred to Committee on Medical and Dental Laws). Amending Optometry Act.

Assembly Bill 1222, by Lyon (referred to Committee on Public Health and Quarantine). Regulating traffic in cosmetics.

Assembly Bill 1254, by Lyon (referred to County Government). Authorizing counties to recover cost of care of harmless insane.

Assembly Bill 1255, by Lyon (referred to Committee on County Government). Amending Psychopathic Parole Act, to authorize counties to recover cost of care of persons mentally disordered.

Assembly Bill 1263, by Lyon (referred to Committee on County Government). Authorizing Boards of Supervisors to provide for the creation and operation of a system of insurance and pension for the benefit of physicians and nurses employed in county institutions, to procure group insurance for the benefit of such employees and to provide for the payment of premiums therefor.

Assembly Bill 1272, by Lyon (referred to Committee on Public Health and Quarantine). Amending Cosmetology Act.

Assembly Bill 1299, by Cunningham (referred to Committee on County Government). Relating to county charges.

Assembly Bills 1302 and 1303, by Boyle (referred to Committee on Medical and Dental Laws). Amending Pharmacy Act.

Assembly Bill 1308, by Field (referred to Committee on Public Health and Quarantine). Amending Cosmotology Act.

Assembly Bill 1347, by Boyle (referred to Committee on Public Health and Quarantine)—Skeleton bill. Members of Board of Health.

Assembly Bills 1353 and 1354, by Desmond (referred to Committee on Public Health and Quarantine)—Skeleton bills. Board of Health.

Assembly Bill 1355, by Patterson (referred to Committee on Medical and Dental Laws)—Skeleton bill. Medical Practice Act.

Assembly Bill 1361, by Hunt (referred to Committee on County Government)—Skeleton bill. County hospitals.

Assembly Bill 1367, by Riley (referred to Committee on Public Health and Quarantine). County Sanitation Districts.

Assembly Bill 1543, by Maloney by request (referred to Committee on Judiciary). Relating to alienists in criminal cases.

Assembly Bill 1544, by Maloney by request (referred to Committee on Governmental Efficiency and Economy). Relating to state psychiatrists and the establishment of a division of psychiatry in the Department of Institutions.

Assembly Bill 1545, by Maloney by request (referred to Committee on Crime Problems). Examination of persons charged with crime.

Assembly Bill 1552, by Anderson and Boyle (referred to Committee on Governmental Efficiency and Economy). An act to establish a State Board of Qualifying Certificate Examiners in the fundamental sciences underlying the practices of the healing arts, to provide for its organization and powers, to provide that certification by such a board be a prerequisite to eligibility for examination for a license to practice the healing arts and to define healing arts—basic science.

Assembly Bill 1607, by Johnson, Fisher, Breed, Corwin, Cunningham, Martin, Wallace (referred to Committee on Governmental Efficiency and Economy). Creating State Board of Eugenics.

Assembly Bill 1615, by Redwine and Martin (referred to Committee on Public Health and Quarantine). An act to restrain aliens who are or may become invalids or infected with diseases from entering the state.

Assembly Bill 1672, by Cottrell (referred to Committee on Hospitals and Asylums). Appropriation for construction Department of Institutions.

Assembly Bills 1673 and 1674, by Cottrell and Anderson (referred to Committee on Hospitals and Asylums). Appropriations for Agnews.

Assembly Bill 1690, by H. J. Evans (referred to Committee on Insurance). Amending workmen's compensation relating to medical treatment.

Assembly Bill 1765, by Cronin (referred to Committee on Medical and Dental Laws). An act to establish standards for the granting and use of professional degrees in the learned professions and providing penalties for the violation thereof.

Assembly Bill 1788, by Crowley (referred to Committee on Hospitals and Asylums). Appropriations for Napa.

Assembly Bill 1839, by O'Donnell (referred to Committee on Medical and Dental Laws). An act to provide for the adoption of a uniform narcotic drug act.

Assembly Bill 1840, by O'Donnell (referred to Committee on Medical and Dental Laws). An act regulating traffic in narcotics.

Assembly Bill 1866, by Reeves (referred to Committee on Insurance). Amending Compensation Act.

Assembly Bill 1872, by Boyle (referred to Committee on Judiciary)—Skeleton bill. Bonds for costs in civil action for malpractice.

Assembly Bill 1909, by Patterson (referred to Committee on Insurance). Health Insurance Act.

Assembly Bill 1918, by Clark (referred to Committee on Insurance). Adding section to Compensation Act relating to hospital records of persons receiving compensation thereunder.

Assembly Bill 1919, by Clark (referred to Committee on Insurance). Amending Compensation Act relating to presumptions in respect to injuries to employees.

Assembly Bill 1925, by Reaves (referred to Committee on Medical and Dental Laws). Relating to disposition of human bodies.

Assembly Bill 1927, by Flint (referred to Committee on Hospitals and Asylums). Relating to tuberculosis subsidies.

Assembly Bill 1928, by Flint (referred to Committee on Hospitals and Asylums). Relating to tuberculosis bureaus.

Assembly Bill 1929, by Flint (referred to Committee on County Government). Skeleton bill.

Assembly Bill 1943, by Scudder (referred to Committee on Medical and Dental Laws). Providing for regulation of laboratories.

Assembly Bill 1946, by Miller (referred to Committee on Medical and Dental Laws). Relating to traffic in narcotics.

Assembly Bill 1947, by Miller (referred to Committee on Medical and Dental Laws). Amending Nursing Act.

Assembly Bill 2154, by Riley (referred to Committee on Public Health and Quarantine). Establishment of a bureau in Board of Public Health for suppression of noxious odors.

Assembly Bill 2158, by Clark (referred to Committee on Judiciary). An Act making it unlawful for hospitals, clinics, sanitariums, physicians, surgeons, or any other persons to refuse inspection of records by attorneys.

Assembly Bill 2209, by Clark (referred to Committee on Insurance). Amending Compensation Insurance Act relating to testimony by physicians.

Assembly Bill 2216, by Richie (referred to Committee on Insurance). Amending Compensation Act.

Assembly Bill 2286, by Lore (referred to Committee on County Government). Relating to the powers of boards of supervisors.

Assembly Bill 2304, by Flint (referred to Committee on Hospitals and Asylums). An Act to provide for the regulation of the organization and operation of hospital associations.

Assembly Bill 2305, by Hornblower (referred to Committee on Medical and Dental Laws). Amending Medical Practice Act relating to chiropody.

Assembly Bill 2371, by O'Donnell (referred to Committee on Medical and Dental Laws). An act to provide for the adoption of a uniform narcotic drug act.

Assembly Constitutional Amendment 46, by Reaves (referred to Committee on Constitutional Amendments). Relating to practice of chiropractic.

* * *

ANOTHER SUMMARY OF SOME PROPOSED CALIFORNIA LEGISLATION

From *The Journal of the American Medical Association*, February 16, 1935, page 568, the following is quoted because of the additional information contained therein concerning some of the proposed California laws:

S. 98 proposes to make it unlawful, except for licensed physicians and for persons licensed specifically by the State Board of Health so to do, to perform diagnostic tests on cultures or material from persons suffering from infectious or contagious diseases. S. 309 proposes that any person convicted of distributing unlawfully narcotic drugs, who is himself not a narcotic addict, may be punished, in addition to the other penalties provided by the Act, by from one to twenty lashes at a whipping-post. S. 391 proposes to establish a system of compulsory and voluntary health insurance. The bill was introduced only by title, however, and the remainder of the bill is to be inserted by the Committee on Public Health and Quarantine, to which this bill has been referred. S. 392 proposes to make it unlawful to conduct a clinical laboratory unless it be under the immediate direction of a licensed clinical laboratory technologist licensed by the State Board of Health. The State Board of Health is to license as a clinical laboratory technologist any licensed practitioner of the healing art who has specialized in general clinical laboratory work, such as bacteriology, serology, biochemistry and parasitology, and other allied subjects for at least three years. It is also to license (1) any other person who for more than eight years has been engaged continuously and actively in the work and direction of a clinical laboratory and (2) any other person who can qualify by written and practical examinations to be given by the board. The provisions of the bill, however, are not to apply to any licensed physician maintaining a laboratory in his own office for use in his own practice. S. 413 prohibits the employment of pharmacists and pharmacy clerks for more than an average of six hours a day, for more than seventy-two hours in any two consecutive weeks, or for more than twelve days in any two consecutive weeks. A. 416, to amend the Workmen's Compensation Act, proposes to permit chiropractors to render the "medical" care to injured workmen for which the Act makes the employer liable. A. 551, to amend the laws regulating the operation of maternity hospitals, proposes to make it unlawful for any such hospital to offer, as an inducement to a woman to enter therein, to dispose of her child or children for adoption. A. 603, to amend the law relating to county hospitals, proposes to require the admittance of any expectant mother, unable to pay for the necessary care, to any county hospital, regardless of her length of residence in the county. A. 761, to amend the Retail Sales Tax Act of 1933, proposes to exempt from its provisions the gross receipts from the sale of medicine and medical supplies. A. 890, to amend the provisions of the Medical Practice Act with respect to chiropody, proposes (1) to make the words "chiropody" and "podiatry" synonymous and (2) to define "mechanical treatment," which chiropodists are authorized to employ, as the employment of appliances to the plantar or lateral surfaces of the foot or feet, or of pads, or the use of adhesive tape strappings, or any forcible means for the correction or treatment of any deformity of the foot or feet but does not permit the treatment of fractures of the bones of the foot or feet or the application of splints or casts; provided, however, that the manufacture, the recommendation or the sale of corrective shoes or appliances for the human feet shall not be considered as mechanical treatment. A. 1037 proposes to make it unlawful for any person to own, possess or operate any x-ray device or x-ray laboratory unless such device or such laboratory is operated under the direct supervision of a person licensed by the State Board of Health. Apparently only licentiates of the Board of Medical Examiners, licensed osteopaths and licensed dentists are to be eligible for licensure by the Board of Health. Such practitioners are to be permitted to possess and use such devices "as are incident to the treatment of patients by means other than x-ray or x-ray devices."

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 3, March 1910

From Some Editorial Notes:

Annual Meeting.—The Committee on Arrangements announces that the meetings of the State Society at Sacramento, April 19, 20, and 21, 1910, will be held in the Elks Building, which is located conveniently near the Hotel Sacramento. . . . Get out of the rut; go to the annual meeting; meet several hundred of your fellow physicians; learn something new; teach something that you have found out and that others ought to know. Go to the meeting, even if at some sacrifice. . . .

* * *

Ring Talk.—In the State Society, in many, if not all county societies, in every sort and form of organization of men, you will hear the same sort of talk: that things are run by a "ring," and "clique," a "machine." And it is perfectly true; all organizations of men are always managed and conducted—or "run"—by a few men who will give their time and their energy to the necessary work; probably very few of those who do the work would not be glad to be quit of it, if someone else would step forward and relieve them. . . .

* * *

Plague News.—The many friends of Dr. Rupert Blue will be glad to know that he has been made a Fellow of the Royal Society of Tropical Medicine of London in recognition of his remarkable work in fighting plague in San Francisco. . . .

* * *

Public Health Commission.—The Public Health Commission of the State Society is, as all of our members know, one of the most active bodies or committees connected with the Society. Since its very inception this Commission has done a good deal of the very best, high-grade work. . . .

* * *

Open Meetings.—At the last session of the American Medical Association a resolution was introduced and passed, requesting all county medical societies to hold at least one open or public meeting each year. Such meetings will be of the very greatest benefit; the people generally do not know what medical societies are trying to do; they do not understand our present-day efforts toward the betterment of public health matters; they are at sea as to the real reason for proper medical laws and for the compulsory vaccination of children. . . .

* * *

"What Fools These Mortals Be."—In *Life,* a weekly publication more noted for its smartness than its wit, and which is supposed to throw the searchlight upon the follies, foibles, sins, whims and caprices of humankind, there recently appeared a two-page illustration entitled "The Reward of Virtue." . . . This is *Life's* idea of humor; its tribute to the medical profession—for it wishes to imply that the blood-thirsty individual is a physician. . . . This horrible illustration, so unwholesome that it should have been suppressed by the authorities, is not without purpose. It is this silly journal's contribution to the fight which is being made against the Rockefeller Institute of Medical Research by certain fanatics in New York. . . . That the mortality in cerebrospinal meningitis has been reduced from 75 to 25 per cent is mere drivel to these misguided sentimentalists. People who do not choose to fight fair are not open to argument. . . .

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, page 17)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M. D.
Secretary-Treasurer

Official Notices

Board Proceedings.— At a regular meeting of the Board of Medical Examiners held in Los Angeles February 4 to 7, inclusive, seventy-two applicants wrote the examination.

Twelve licentiates were called before the Board on charges of violations of Section 14 of the Medical Practice Act. The following changes in the status of licentiates were made:

Stanley Boller, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on five years' probation, without narcotic privileges.

Brandon A. Bowlin, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on probation for a period of three years, without narcotic privileges.

Ethel L. Leonard, M. D., found guilty of narcotic derelictions, was, on February 6, 1935, placed on probation, without narcotic privileges.

Edward P. Genochio, M. D., found guilty on February 6, 1935, under Subdivision 8 of Section 14, re advertising, was placed on probation for three years.

Hovsep H. Mahdesian, M. D., found guilty of narcotic derelictions, was, on February 7, 1935, placed on probation for a period of two years, without narcotic privileges.

Louise Patterson, M. D., found guilty on a charge of use of fictitious name, was, on February 7, 1935, suspended from practice for a period of two years.

William T. Schwabland, M. D., charged with use of fictitious name, was, on February 6, 1935, suspended from practice for a period of one year.

The charges against George H. French, M. D., deceased; LeRoy B. Humphrey, M. D., and Henry F. Kamman, M. D., were dismissed.

The case of Byron H. Pelton, M. D., charged with narcotic dereliction, was partially heard, and continued to the San Francisco meeting, which opens July 8.

News Items

"A bill to provide for the licensing of all persons who perform laboratory tests on materials taken from persons suffering from infectious or contagious diseases, was introduced in the Senate by Senator Herbert W. Slater of Sonoma County. The bill is in line with another by Slater, providing for the control by the State of dispensing of serums and requiring that dispensers be licensed. Both measures are the outgrowth of the death of a two-year-old boy in Healdsburg last year after receiving an injection of infantile paralysis serum." (Sacramento *Bee,* January 18, 1935.)

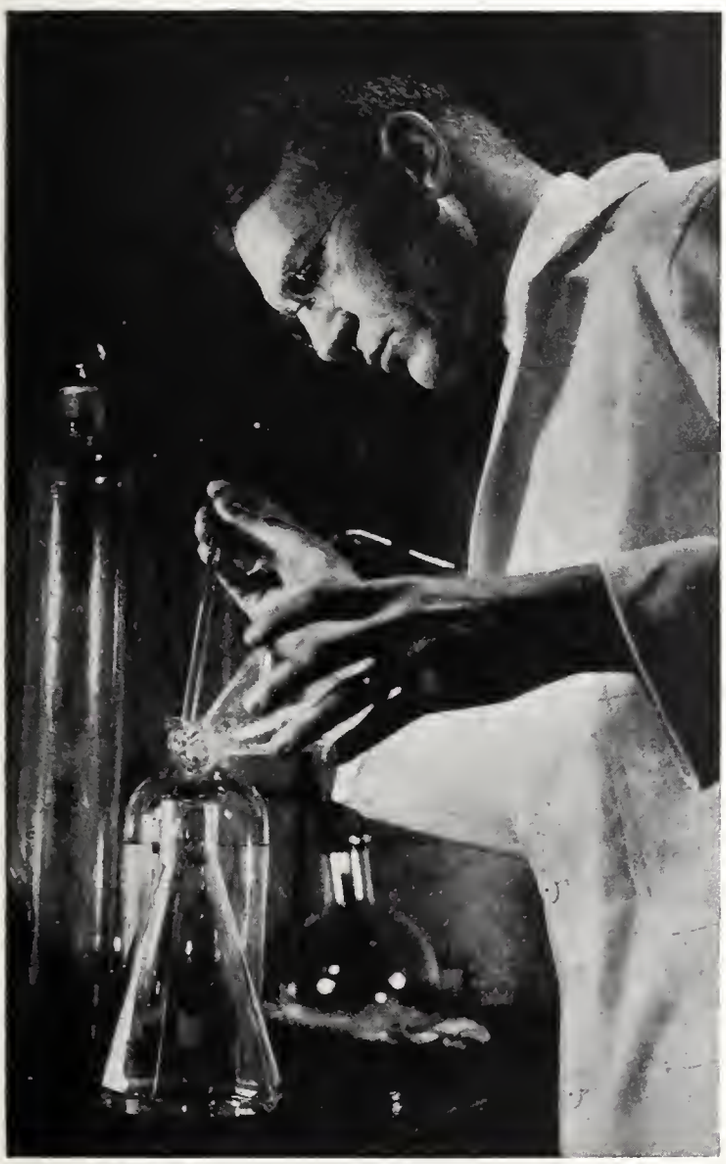
"Chiropractic doctors, operating under the State Act prescribed for them, won two decisions in the District Court of Appeal yesterday. The high court, however, declined to pass upon the scope of Section 7 of the Act to differentiate between chiropractic and the medical profession practice. An action brought through *quo warranto* proceedings by the State and the Chiropractic League of California against Dr. Roscoe C. Steele and his wife, Lois, Palo Alto, in which they were enjoined from practicing by Superior Judge James of Santa Clara County, was reversed. At the same time the high court held that a contract between Dr. M. James McGranaghan for service did not include in its scope attention that might be construed to be under other medical jurisdiction." (San Francisco *Chronicle,* January 29, 1935.)

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, page 18)



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Two Decades of Medical Research.*—In many ways the past twenty years have been the most fruitful in medical research in the history of medicine. If I succeed at all in covering the main incidents of that period, I think you will agree that it was a highly significant one; and I need not say to you that it is utterly impossible to do adequate justice to the subject in the brief time at my disposal. You will quickly discover that what I shall recall or describe as advances in knowledge during the past twenty years relate to those particular subjects concerning which I have some personal experience. Please remember that this account does not exclude by disregard the advances that have been made in other fields in which I have no experience and of which I am largely ignorant. . . .

We may consider advances made in medical knowledge in two ways. We may profitably view the changing picture of disease which has taken place in twenty years. In this way we shall find certain diseases common twenty years ago which are now in process of reduction, even up to the point of disappearance. The disease *chlorosis* falls into this category, and although no precise reason can be given for the change, we shall probably not be far wrong if we ascribe it to the greatly improved state of general hygiene prevailing at the present time.

Another instance which comes to mind relates to the "open" cases of *bone* and *gland tuberculosis*. Here we are on surer ground in attributing improvement to the elimination of bovine tuberculosis, through testing cattle with tuberculin, to the pasteurization of milk supplies, and to a rise in the general effectiveness of operative surgery.

At this point, reference is desirable to *diphtheria* and *scarlet fever* immunization, the latter coming well within the twenty-year period. It may be pointed out that the newer method of diphtheria immunization, by means of anatoxin, which is a modified, relatively non-poisonous form of the toxin of the diphtheria bacillus—the agent relied upon for the production of immunity in children—avoids the drawback of inducing horse serum sensitiveness in those treated; and that the highly profitable studies on hemolytic streptococci, carried out in the New York State Laboratory, have led to great improvement in the manufacture of antistreptococcus serum used for the treatment of cases of scarlet fever.

Into this changing picture of disease we may introduce the benefits which have accrued from the laboratory and clinical studies of certain other disorders. Two or three incidents only can be referred to here: the employment of insulin in the management of *diabetes*, and of liver extract in the treatment of *pernicious anemia*. The liver extract treatment of pernicious anemia is one of the most brilliant medical discoveries of the past twenty years.

As the sources of disease are being more deeply investigated, it is becoming more and more apparent that the essential causative agents are chemical in nature; and this is true whether the disease is induced by an external agent implanted in the body, as in the infections, or whether it arises from deficiencies of food intake (vitamins), or defective behavior of those essential organs, the endocrines or glands of internal secretion.

It is due to the discoveries alluded to that progress is being made in the specific treatment of disease. Although it has happened through chance, or trial and error tests made on man himself, that two specific, curative substances were discovered in the long past—I refer to cinchona bark and its alkaloid, quinin, and mercury—the experimental method of today is prov-

* Abstract of an address by Simon Flexner, M. D., Director of The Rockefeller Institute for Medical Research, New York City, at the Annual Conference of Health Officers and Public Health Nurses, at Saratoga Springs, N. Y., June 26, 1934.



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ing incalculably more rewarding, as becomes evident immediately on passing in review a few of the specific agents yielded by the laboratory, which include immune sera—salvarsan and bismuth in the treatment of *syphilis,* and tryparsamid in the treatment of African *sleeping sickness* and *paresis.*

Just as discoveries in connection with the vitamins have greatly aided in the prevention and treatment of diseases due to dietary and related errors, so vivid light is being thrown on the sources of certain obscure metabolic diseases by investigations of the *endocrine glands* now in progress. To refer briefly to the pituitary gland alone is to open up a fascinating and romantic chapter in modern medicine. That gland which, as you know, sits at the base of the brain, provides a secretion that affects growth, gonadic activity, the function of the thyroid and probably of the adrenal; it coöperates in the production of diabetes, and regulates milk formation; and this long list of activities probably does not exhaust all its functions on which the issue of health or disease depends. The way to study most profitably the functions of these glands was shown by the success achieved in the study of vitamins, or by combined physiological and chemical experiments carried out on laboratory animals.

The decade of 1880 to 1890 is distinguished in medical history as the *bacteriological era.* It witnessed the fruition of the discoveries of Pasteur, Koch, and Lister. It was succeeded by the *immunological era* of Behring, Ehrlich, Theobald Smith, and a host of others. The last two decades have brought almost a parallel in the discoveries in connection with the virus diseases of man, the lower animals, and plants. The number of *virus diseases* must be very large, and may even exceed the number of bacterial diseases. What is of overwhelming importance for us is the fact that the viruses are responsible for some of the most widely spread and destructive epidemic diseases of mankind. Among these, we can already name with certainty poliomyelitis, yellow fever, certain forms of encephalitis, as well as smallpox and probably influenza. The virus of mumps was discovered just the other day.

In this cursory review I have attempted to bring before you some of the signal advances in medical science, the results of the experimental studies being carried out mainly during the past two decades. It seemed to me that in celebrating today the twentieth anniversary of the enactment of the Public Health Law, this was a suitable thing to do. The purposes of the law are so broadly scientific, and the law recognizes so directly the growth and changes in the scientific basis of medical practice, both in the preventive and curative aspects, that a bond exists between the two purposes, namely, public health administration on a high plane, and the discovery and application of new knowledge secured in the laboratory and at the bedside.

Mr. Milbank Speaks for the Milbank Foundation.—In the address given by Mr. Albert G. Milbank, president of the Milbank Memorial Fund, before the annual conference of secretaries of the county medical societies of Indiana on January 27, he gave every evidence of a friendliness to the members of the medical profession and a sincere desire to coöperate with them in carrying out the purposes of the fund in accordance with the hopes of its founder, Mrs. Elizabeth Milbank Anderson.

In order to clear up the misunderstandings which have arisen between groups whose interests and pur-

(Continued on Next Page)

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(Continued from Preceding Page)

poses call for mutual understanding and coöperation, Mr. Milbank outlined the position of the Milbank Memorial Fund in the field of health and the relations it would like to see established between it and all other groups operating in that field in which the members of the medical profession are obviously pre-eminent.

To get a proper perspective he said that the fund was spiritually and financially the embodiment of a wise and generous woman who, fifty years ago, began a series of noteworthy gifts which continued uninterruptedly until her death in 1921, and whose carefully considered philanthropic philosophy the fund, which she established in 1905, adopted as the basis of its own policy. He spoke of Mrs. Anderson's characteristics as an individualist with a deep sense of her social obligations and as a conservative who recognized that the world does not stand still and that the cause of conservatism is best served, not by an unreasoning resistance to any change whatsoever, but by a willingness to make reasonable changes in forms and procedures while preserving the sound principles which, like the eternal verities, persist because they are in fact based on truth. He pointed out that with such a tradition it would be quite out of character if the Milbank Fund would seek to undermine those foundations of the practice of medicine which have been tested and found good or to discredit the front line troops upon which everyone must rely to win the common fight for better health for the people of the United States.

He said that the question of medical economics is only one phase, although a most important one, of a larger subject which is engaging the world's attention and which involves the conflicting philosophies of individualism and socialism.

Mr. Milbank briefly described the organization of the fund, with its auxiliary committees known as its Technical Board and its Advisory Council, and stated that in matters of policy and of expenditure the sole responsibility rested with the Board of Directors, which has taken no action on the subject of medical economics. He said that the staff of the fund, with the knowledge and informal approval of the directors,



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has been engaged in making studies in relation to this subject; that such studies were not yet complete and, therefore, no final report by the staff has been made. The members of the staff had released interim reports, including tentative conclusions for the purpose of arousing discussion and criticism.

Mr. Milbank then gave his own understanding of these proposals, which do not purport to be a health insurance plan worked out in all of its administrative and financial details, and the reasons why they have seemed to him worthy of serious consideration. He spoke of the similarity between the principles embodied in these proposals as advocated by members of the fund's staff and the principles recently adopted by the American Medical Association, American Dental Association, and other professional groups. He also mentioned other points where there seemed to be a general agreement should a health insurance plan ultimately be adopted. He said that his own interest in this subject was first aroused because the idea appeared to accomplish the dual purpose of promoting the health of the public and at the same time of operating for the benefit of the practicing physicians.

He frankly admitted that unless great care was taken the plan in its administration might be open to abuses that would offset, in whole or in part, the advantages which were apparent on the face of the proposals that have been advanced. He referred to the importance of avoiding the evils of bureaucracy and political influence. He said that there must be no repetition of the defects disclosed in the administration of the Workmen's Compensation Laws, and spoke of the importance of maintaining a spirit of self-reliance and of self-respect among the insured group.

He urged, however, that the difficulties should not prevent a dispassionate consideration of the problem which in its present status leaves much to be desired. He expressed a hopeful view that the advantages

(Continued on Next Page)

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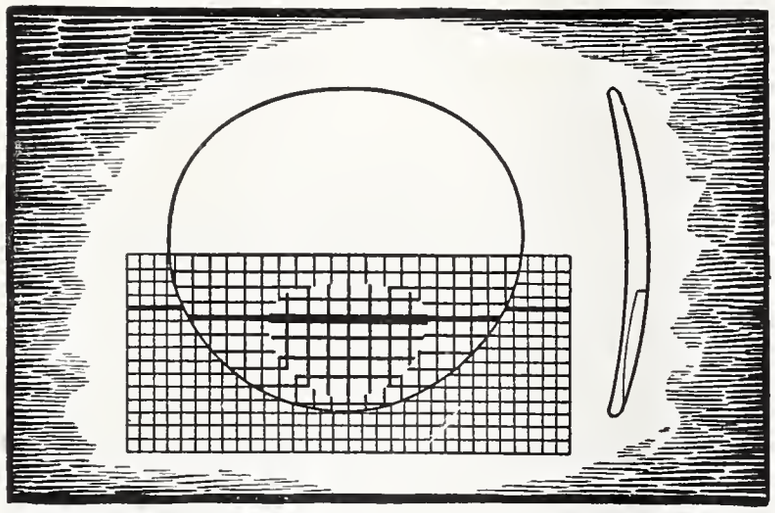
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could be secured and the difficulties largely minimized, if not wholly eliminated, provided the doctors themselves become wholeheartedly determined to make a plan of health insurance a success.

Mr. Milbank spoke of the number of activities of the Fund which have been conducted in close coöperation and with the support of practicing physicians. He expressed the view that a foundation interested in the subject of public health can be of great benefit to the medical profession if only a basis of helpful coöperation can be established.

Reference to representation of various groups—medical, public health, nursing, and others—on the Fund's Boards of Council indicated that the Fund intended to go still further in this direction and was in the process of forming a medical committee to collaborate with the staff of the Fund in such further studies that may be appropriate after the results of the conferences now pending in Washington under the auspices of the President's Committee on Economic Security are known.

Mr. Milbank expressed the belief that if the true nature of the proposals of the staff were understood it would be seen that instead of favoring state medicine they were intended to forestall the movement in that direction.

Mr. Milbank concluded his remarks with the statement that no one can deny that the subject of health is affected with the public interest nor can anyone deny that the practice of medicine is a gainful occupation and, therefore, affected with a private interest. He expressed his personal belief that if a soundly conceived health insurance plan is worked out it will be found that there is no conflict between the public interest and the private interests of the practicing physicians.

Provided there is a recognition by the medical profession that a foundation interested in promoting the public health has a right to offer proposals calculated to promote that object, and a recognition by such a foundation that the medical profession must play an all-important part in making such proposals effective, and that the private interests of the physicians must be safeguarded, a basis for mutually helpful coöperation will thereby be established.

As a danger to the public health, as a peril to the family, and as a menace to the vitality, health and physical progress of the race, the venereal diseases are justly regarded as the greatest of modern plagues, and their prophylaxis the most pressing problem of preventive medicine that confronts us at the present day.—M. J. Rosenau.

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Pointers on Swimming-Pool Sanitation.*—The interest of the public is somewhat focused on swimming during an outbreak of acute anterior poliomyelitis and some people question the advisability of continuing this sport at such a time. It is, therefore, imperative that those engaged in the operation of swimming pools be guided by the advice of the health officer.

Normal mucous membranes of the nose and throat are protective against this virus as against other infections of the upper respiratory tract. Flushing of the nose and throat, as occurs in certain forms of swimming, is obviously undesirable. Vigorous endeavors must be extended by all pool managers and operators in maintaining a high standard of sanitation and in enforcing the following:

1. All swimmers, and children in particular, shall be instructed to avoid diving and under-water swimming as much as possible and to try to swim with nose and mouth above water.

2. Blowing out of the nostrils, and spitting in pool or on sidewalks, and "bellowing" of swimmers, shall be prohibited as much as possible.

3. Scum Gutters. Maintain a high water level so that scum gutters overflow the floating scum and sputum continuously to the sewer. Keep gutter clean and keep sputum and scum off of water as much as possible. If gutter drains are inadequate, install more drains. Disinfect scum gutters with a solution (see 4).

4. Cleaning of Floors and Walks. Wash down floors and walks two or three times daily, and sprinkle a chlorin solution over floors at least twice daily. For a solution, use four ounces of any chlorin chemical in five gallons of water. In the case of dirt walks, sprinkle with cresol solution made from any cresol preparation having about 50 per cent phenol coefficient, and using four ounces per gallon of water.

5. Suits and Towels. Thoroughly wash and rinse suits and towels and dry thoroughly in the sun wherever possible before being reused.

6. Excluding Sick Persons. Keep out persons having symptoms of colds or inflamed eyes or indications of fever. Do not allow children or others to remain in water so long that they become chilled or fatigued.

7. Changing Water. Increase frequency of changing water wherever feasible, and especially following days of heavy patronage. For example, in the case of fill and draw pools, change water daily on week-ends and holiday periods and every other day during the week. Pools equipped with complete disinfection, filters, and circulating pumps should also increase the frequency of changing the water as fully as is possible in each case.

8. Chlorination. Keep chlorin in the swimming pool all day long, but be careful to avoid using an amount which will result in stinging of eyes, nose or throat. Maintain the free chlorin at not less than .2 parts per million in order to get disinfection. If the customary .5 parts per million for maximum value causes any stinging of the eyes, cut down the upper limit while this epidemic is on. Make tests for chlorin in the pool three or four times per day at five or six points around the pool, to be sure you are chlorinating correctly, and keep a record of each test. For test purposes use Orthotolidine solution.

Operators of pools not equipped for continuous chlorination must apply chlorin by hand. Make up the necessary solution and scatter over the surface of the pool at least three times daily. As a rough indication of the amount necessary for a 100,000 gallon pool, figure on one pound of active chlorin per day. This amount will be found in three pounds of fresh chlorid of lime, or in 1.5 pounds of H. T. H., or in slightly over one-half gallon of commercial sodium hypochlorite (20 per cent chlorin). Common trade names are Clorox, Luxol, Saniclor, Purex, etc.

In using chlorid of lime, first make up the amount into a creamy paste, then dnlute into five gallons of water to make the solution and strain it through cheesecloth.

Apply one-half the required amount of the particular chemical to the swimming pool in the morning before swimming starts, and half of the remainder about noon, and the remainder about three o'clock. However, the amount of chemical used and its frequency of use will need to be varied, as the bathing load, changes in temperature of water, and perhaps other factors affect the disappearance of the chlorin.

Stock up with chlorin chemicals so as not to get caught short. Get yourself an Orthotolidine test outfit and at least a pint of Orthotolidine solution. If not familiar with sources of these supplies, consult your druggist, or firms listed in the business guide of the telephone directories of the larger cities, under the headings "Chemical Business," and "Chlorination."

* Issued by Bureau of Sanitary Engineering of the California State Department of Public Health for distribution to operators and owners of public swimming pools June 18, 1934.

Error is the force that welds men together; truth is communicated to men only by deeds of truth.—Tolstoi.

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B. A., Dartmouth; M. A., Harvard

BOOK REVIEWS

List of Books Received

BOOKS RECEIVED

Martini's Principles and Practice of Physical Diagnosis. Edited by Robert F. Loeb, M. D., Associate Professor of Medicine, College of Physicians and Surgeons, Columbia University, and Presbyterian Hospital, New York City. From the Authorized Translation by George J. Farber, M. D. Cloth. Pp. 213, with thirty illustrations in the text. Price, $2. Philadelphia: J. B. Lippincott Company, 1935.

The Nervous Patient. A Frontier of Internal Medicine. By Charles Phillips Emerson, M. D., Research Professor of Medicine, Indiana University, Indianapolis. Cloth. Pp. 453. Price, $4. Philadelphia: J. B. Lippincott Company, 1935.

International Clinics. A quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest. By leading members of the medical profession throughout the world. Edited by Louis Hamman, M. D., Visiting Physician, Johns Hopkins Hospital, Baltimore, Maryland. Volume I. Forty-fifth Series, 1935. Cloth. Pp. 310. Philadelphia: J. B. Lippincott Company, 1935.

Tuberculosis. A Book for the Patient. By Fred G. Holmes, M. D., Director of the National Tuberculosis Association; Chief of Staff, Good Samaritan Hospital, Phoenix; President-elect, Arizona State Medical Society; Fellow of the American College of Physicians. Cloth. Pp. 312. Price, $2. New York: D. Appleton-Century Company, 1935.

Memoirs of a Small-town Surgeon. By John Brooks Wheeler, A. B., M. D., Sc. D., F. A. C. S., Emeritus Professor of Surgery, University of Vermont, College of Medicine. Cloth. Pp. 336, with reproductions of a portrait and three photographs. Price, $3. New York: Frederick A. Stokes Company, 1935.

Elementary Human Anatomy. Based on Laboratory Studies. By Katharine Sibley, Professor of Physical Education, School of Education, Syracuse University, Syracuse, New York. Cloth. Pp. 380, with 213 illustrations. Price, $4.50. New York: A. S. Barnes and Company, Inc., 1935.

The Patient and the Weather. By William F. Petersen, M. D., with the Assistance of Margaret E. Milliken, S. M. Volume II, Autonomic Disintegration. Cloth. Pp. 530. Price, $6.50. Ann Arbor: Edwards Brothers, Inc., 1934.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 336)

From an article on "Selected Chapters from the Study of Speech Disturbances" by Henry Horn, M. D., San Francisco.

1. *The Treatment of the Stutterer.*—A glance at any of the weekly papers or the morning dailies will convince one that the public has not yet given up hope of finding a patent cure for stuttering. If one for a moment considers what the advertisements must cost the inventors of these wonderful cures, it will be seen that the number of people who are suffering from speech disturbances must be very large. . . .

From an article on "Labyrinthitis"—Its Physiology, Methods of Diagnosis, with Report of Two Cases, by Dr. Grant Selfridge, San Francisco.

Since the publication of the articles by Richards of New York in 1906, on the surgery of the labyrinth, and that of Jensen in 1907, "On the Treatment of In-

(Continued on Page 13)

IMPORTANT NEW BOOKS

Wiener: Blood Groups and Blood Transfusion	$4.00
Duke-Elder: Practice of Refraction	4.00
Graham: Diseases of the Chest	15.00
Gould's Medical Dictionary, 4th ed.	7.50
Morris: 50 Years a Surgeon	3.50
1934 Yearbook of Dermatology and Syphilology	3.00

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TWENTY-FIVE YEARS AGO

(Continued from Page 11)

fective Labyrinthitis After Fifteen Years' Experience," and the various articles of Alexander, Barany, Neumann, and their English-speaking students, great interest has been shown among the aurists throughout the world in the study of the functional examination of the labyrinth, *i. e.,* the semi-circular canals and cochlea. . . .

From an article on "The Relation of Law to Medicine" by Judge John G. Covert, Kings County.

. . . Law is the ultimate voice of society, establishing rules and regulations found to be necessary for its preservation and progress, and providing for the enforcement of the same.

Medicine has for its object the preservation of life and health, the curing of disease and the alleviation of suffering.

Life and health, next to liberty and happiness, is most desired by man. The object of law being to procure to man those things most conducive to his welfare and preservation, it therefore follows that the law is closely related to medicine. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 336)

F. Haehnlen Vollmer, who is said to have spent several years on the vaudeville stage under the name of Sam Harris, on February 7, 1935, entered a plea of guilty to a charge of violation of the Medical Practice Act and was sentenced to serve 180 days in the county jail, suspended on condition that he no longer violate said Act. Judge Ames warned him that, should any complaint come to the judge's attention of any violations of the Medical Practice Act, he would immediately impose service of the 180 days in the county jail. Reports indicate that Vollmer has traveled about the country for several years posing as a doctor. In his possession were found some prescription blanks on which his name appeared as "Dr.", with the address 4718 South Huntington Drive, Los Angeles, and office hours, with telephone. These, he stated, were printed in Philadelphia in 1915. However, according to our Investigation Department, all Vollmer's statements must be taken with a grain of salt. Perhaps Vollmer's experience as an inmate in the San Luis Obispo and San Francisco city jails may have a deterrent effect on any future attempts on his part to pose as a physician.

M. C. Hin, Chinese herbalist connected with M. J. Young Company, Fresno, on January 28, 1935, pleaded

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

guilty in Fresno to a charge of violation of the Medical Practice Act and was sentenced to serve 180 days in the county jail, suspended on condition that he no further violate the provisions of the law.

"'Seven invisible doctors' were flitting homelessly about Los Angeles last night. With them was 'A. Albertini,' who has been dead for seventy years. With them, too, presumably, were R. A. Miranda, director of the Spanish-American Spiritualistic Association, Inc., his two assistants, C. Rivero and A. Rivero, and some $10,000 belonging to parishioners of Doctor Miranda, who had looked neither wisely nor well into the phosphorescent eyes of the seventeen skulls adorning the walls of the doctor's 'temple' at 430 North Bunkerhill Street. The disposition of the spirits by Detective Lieutenant Bryan and Marshall of the Police Bunco Squad took place yesterday because Mrs. Blanche Gianeini of 424 East Vernon Avenue became a little suspicious after a while. It seems, according to police reports, that Mrs. Gianeini was introduced into 'Doctor' Miranda's flock last January. It did not take the good doctor long to question his seven spirits and discover that they had set aside for her a vast fortune in buried gold. . . . Mrs. Gianeini had both the faith and $2,700, her life's savings. About February 1, according to her story, she deposited the money and was told to come back on February 27 to get her vast fortune, but when she returned she found that 'Doctor Albertini,' another spook, also needed an exhibition of faith. She dropped another $250, borrowed from friends, into the box, together with a $750 diamond ring, and was told to return March 6. When she found the 'temple' vacant last Wednesday, she called the police. . . . One of the 'invisible doctors,' for example, had a favorite prescription which patients purchased at the drug store for $10 a bottle. They left it overnight with 'Doctor' Miranda, to be blessed, according to their story, but when they returned, a spirit had taken the expensive medicine and the bottle was filled with sweetened water. . . ." (Los Angeles *Illustrated Daily News,* March 8, 1935.)

"Dr. Wade H. Walker, Long Beach physician, pleaded guilty before Federal Judge William P. James to one count of an indictment charging him with unlawfully furnishing narcotic prescriptions to addicts.

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Sentence was continued until next December, pending report of probation officers." (Los Angeles *Examiner,* March 8, 1935.)

"Recommending that authorities conduct a further investigation into the death of Miss Charlotte Valentine, 16-year-old Santa Ana High School girl, who died February 4 from an infection, assertedly resulting from an alleged illegal operation, a coroner's jury today heard startling and sometimes conflicting evidence. . . . The crux of the inquest centered on the denials of Dr. Francis Delano Coltrin of Fullerton that he performed an illegal operation on the girl on February 4 at his office. Doctor Coltrin maintained that the girl came to him after having had an operation performed elsewhere and that he merely examined her and made certain that the operation was complete. The physician admitted, however, that he agreed to do the operation, accepted $20 from the girl and kept her watch as security for the remaining payment . . . " (Orange County *News,* February 16, 1935). "Dr. Francis D. Coltrin of Fullerton was released from the county jail yesterday under $15,000 bail, pending his trial March 26, on charges of murder and performing an illegal operation on Charlotte Valentine, sixteen, of Santa Ana, who died February 4." (Santa Ana *Register,* February 21, 1935.) (Previous entry, June, 1935.)

"Dr. W. J. Jacobs entered San Quentin Penitentiary, sentenced to serve fourteen years 'more than life,' apparently undisturbed and comparatively cheerful, according to Sheriff James Ross, who returned last night from delivering to the state prison the man who was sentenced here this week for the murder of Mrs. Lillian Newlon and for attempting to murder Miss Adelaide Flint. . . ." (Santa Barbara *News,* February 16, 1935.)

(Continued on Next Page)



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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"Dr. Donald E. Hickok was charged with murder yesterday and held without bail after a coroner's jury had accused him of performing an illegal operation which cost the life of 17-year-old Marie Cook, high school student. A. S. Rollins, a chiropractor, who had been held in connection with the girl's death, was released at the same time Hickok was charged with murder. Deputy District Attorney John Loucks explained that although the death certificate, purporting to bear Rollins' signature, had been filed, ascribing the girl's death to lobar pneumonia, police were convinced that somebody else had signed Rollins' name. Hickok's offices, they said, adjoin those of Rollins." (Los Angeles *Illustrated Daily News,* February 28, 1935.)

"Frances McNealy yesterday pleaded guilty before Federal Judge George Cosgrove to issuing an unlawful narcotic prescription to an addict. She was admitted to probation for two years and paroled in custody of Dr. W. E. Arnold. Several additional counts of the indictment were dismissed." Los Angeles *Examiner,* February 12, 1935.)

"Dr. C. E. Brown and Allen Mills of Paradise were held to answer to Superior Court here on charges of conspiracy to violate the Medical Practice Act, following their preliminary hearing before Justice of the Peace H. I. Sutherland. They were arrested, following the death of Edward Freeland January 21, after, it is charged, he had been treated for cancer by Mills and Brown. Mrs. Alice Freeland, the widow of the deceased, testified Mills obtained a cancer serum for the patient and this was injected by Brown at the solicitation of Mills. The complaint charges Mills is not licensed to practice medicine and that Brown, upon examining the patient, directed the treatment previously prescribed by Mills be continued." (Sacramento *Bee,* February 19, 1935.) (Previous entries re Allen Mills appeared in June and December, 1925; February, 1926.)

"Dr. G. H. Parchen (chiropractor) was asquitted this week on charges of killing a girl with an illegal operation." (San Diego *Times,* February 8, 1935.)

"Doctor Rutherford Irones today started serving a six months' jail sentence, imposed as the result of his conviction on a hit-and-run charge. He resigned as mayor, following conviction. He was placed on three years' probation, the first six months to be served in the county jail." (San Francisco *Call-Bulletin,* February 15, 1935.)

Who's Who in the Hospital.—The *supervisor* is a graduate nurse who gives the major part of her time to organizing and developing the nursing service and teaching programs in the special clinical divisions for which she is responsible and who shares in the direction and training of head nurses.

The *head nurse* is a graduate nurse who gives the major part of her time to the management of a single ward (usually with about thirty patients) and who assists in carrying out the ward teaching program.

The *general duty nurse,* alias the floor duty nurse, alias the staff nurse, is a graduate nurse who gives the actual care, bedside or other kind, to patients. She may give this care in the wards, in private pavilions, in the operating room, or in the outpatient department.

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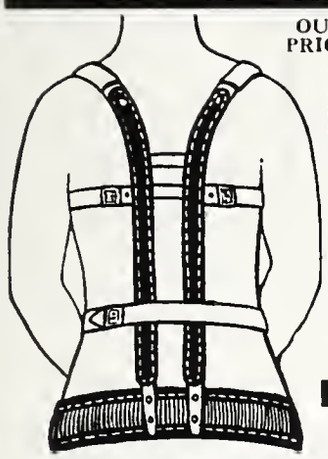
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Doctors daily attend patients who have a complete absence of physical handicap and yet have lost effective functions of the body or parts of it. Always behind such a breakdown the doctor finds a disagreeable life situation which the patient has been unable to master. It can be laid down as a basic principle that when a person of a certain constitution believes that his fight to realize his self-ideal is lost, he becomes ripe for a breakdown.

Some persons are capable of facing the facts of difficult situations and of adjusting themselves to them without undue mental strain. In others, lacking this plastic power to adjust, a nervous strain is developed through a feeling of defeat.

Cirrhosis of the Liver.—The University of California Press Service releases the following item:

John Barleycorn has scored some notable victories in the past year or two, but it looks as though he deserves at least one more wilted laurel leaf on his rakishly titled crown. He can no longer be blamed as the chief cause of that all too common complaint known as cirrhosis of the liver, popularly believed to be a distinctly alcoholic disturbance. He is far from deserving a clean bill of health in this particular, however, for his presence not only paves the way for the disease, but sharply aggravates the condition, once it has become apparent.

In a bulletin descriptive of the disease and its causes, issued through the University of California Medical School by Assistant Professor T. L. Althausen, it is noted that in the laboratory the majority of observers are unable to produce cirrhosis of the liver by alcohol alone. However, when they prepare a nice, tempting diet of other toxic substances and serve them with alcohol, they find that the damage to the liver is greatly augmented. While this may provide a somewhat left-handed sales argument for alcohol and its popular derivatives, it does not offer much of an alibi for Mr. Barleycorn, as far as this particular ailment is concerned.

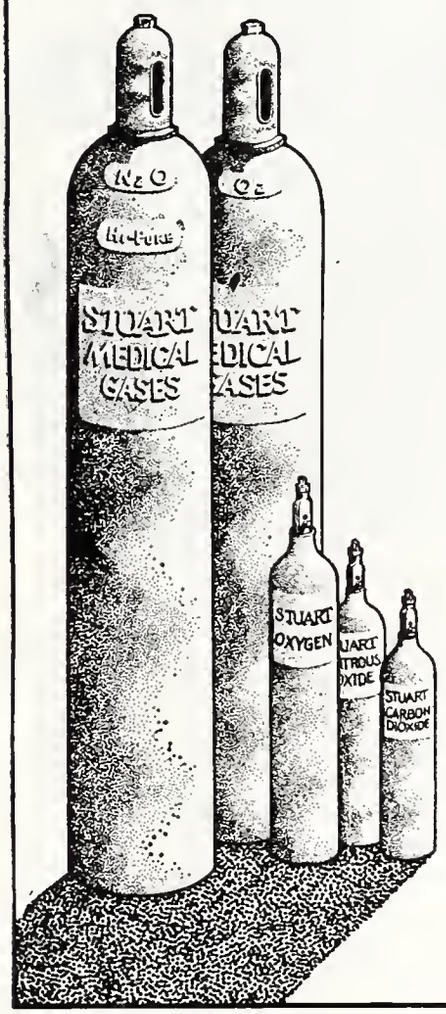
According to Doctor Althausen's bulletin, the marked decline of cirrhosis in the United States in the first few years of prohibition and in Germany during the war, due to difficulties in procuring alcohol, tends to firmly link the potent fluid with this disease. Also the disease is more prevalent in urban than in rural districts, corresponding to the relative consumption of alcoholic beverages. Doctor Althausen also discloses the interesting finding that the disease is more common among men than among women, but includes the condition that it is equally prevalent among women who must have cocktails and kindred refreshments as the principal item of their diet.

And when it comes to the case of the Board of Health or of materia medica versus John Barleycorn, it can also be shown that when the chronic toper with cirrhosis "goes on the wagon," and stays there, a distinct improvement in his condition is often noted.

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Carbon Monoxid in Closed Cars Causes Accidents. There were 612,200 reported motor accidents in the United States during 1932, according to a report published by the Cities Service Company. Of the cars involved, 92 per cent were without known faults in steering, signaling, and vision equipment. Insurance companies studying these accidents found that 95 per cent of the drivers of these cars had no mental or physical defects prior to the accident. The obvious deduction is that, in nine cases out of ten, accidents occur to cars that are in good condition and in the hands of motorists who apparently are physically fit. It is plain that there is some cause for the faculties of the drivers becoming impaired while driving.

According to newspaper reports, automobiles frequently leave the road, often in broad daylight, for no explainable reason. There have also been many accounts of automobiles which, with a clear road ahead, have suddenly veered toward the left side of the pavement and crashed into cars coming from the opposite direction. The frequency of such reports has brought up the question whether some factor other than sleepiness, inattention or negligence may be responsible. Investigations indicate that carbon monoxid is responsible in many instances, for it is a well-known fact that carbon monoxid, which is odorless, tasteless and colorless, may quickly cause unconsciousness in closed spaces even when present in only small quantities.

The need for a device for rapidly testing the amount of carbon monoxid in air without recourse to chemical analysis has been met by an apparatus now on the market which, through the heat generated by the oxidation of the monoxid in a measured quantity of air and its effect on a thermocouple, directly records the amount of the gas on a dial.

Using this apparatus, a commercial concern has tested over a quarter of a million cars for carbon monoxid, working under conditions approved by the National Safety Council. Even in new cars or in cars recently repaired and adjusted, 2 per cent of carbon monoxid is given off in the exhaust gas. In cars with leaky rings, poor timing, etc., the amount may run as high as 13 per cent. Ninety per cent of the cars tested gave off large quantities of unburned or partially burned gases.

The exhaust manifold type of heater blows carbon monoxid directly into the car if there are any leaks or cracks in the exhaust manifold. In one case where the car under test showed no carbon monoxid from the heater, a dangerous amount was immediately recorded when the car was held in traffic behind a bus belching black smoke from the exhaust pipe.

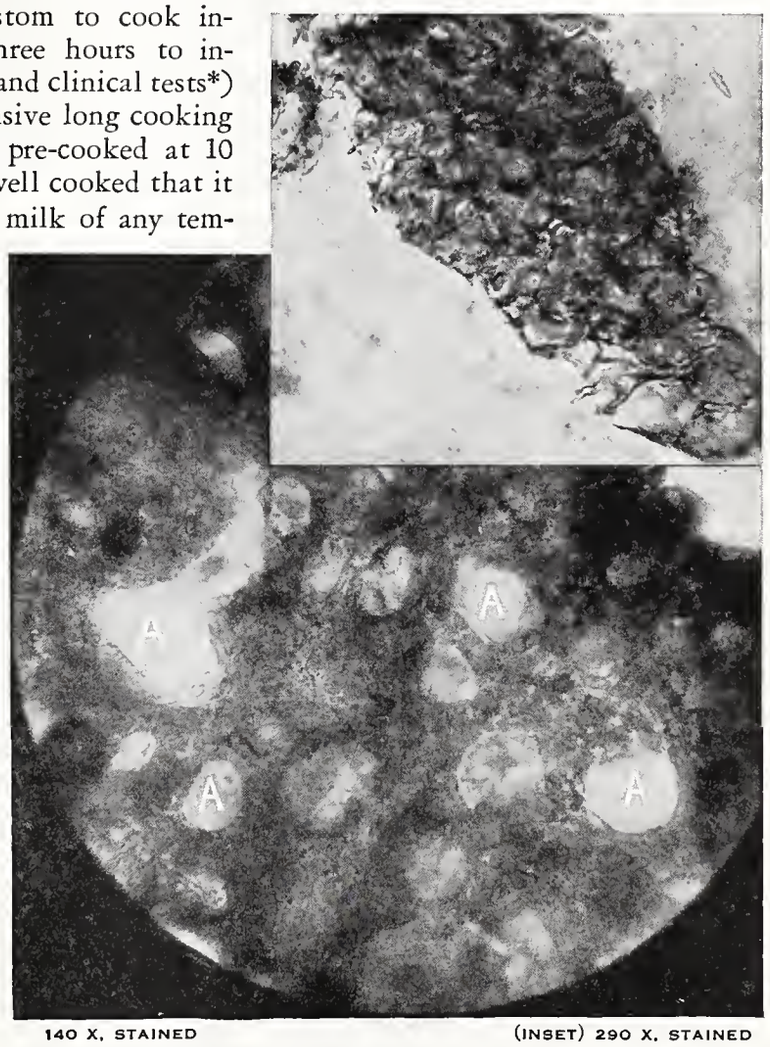
Truck cabs are usually small, so it takes only a little carbon monoxid to effect a dangerous concentration. Many trucks are kept so continuously in use that needed repairs are not made even when it is known that there are leaks in the exhaust system. In one fatal case recorded in *The Travelers Standard*, a publication issued by the Travelers Insurance Company, the driver evidently had inhaled sufficient monoxid to cause a severe headache, as a box of aspirin tablets

(Continued on Page 20)

The cereal-starch* of PABLUM is more quickly digested than that of long-cooked cereals

FOR many years it has been the custom to cook infants' cereals one, two, and even three hours to increase their digestibility. The microscope (and clinical tests*) now prove that this bothersome and expensive long cooking is unnecessary with Pablum. For, being pre-cooked at 10 pounds steam pressure and dried, it is so well cooked that it can be served simply by adding water or milk of any temperature. Photomicrographs and also digestibility studies *in vitro* give evidence of this thorough cooking.

Fifteen cereals (both cooked and uncooked) studied microscopically were revealed as containing many starch granules, most of them massed into dense clumps. *Such unruptured clumps were never observed in hundreds of examinations of Pablum.* The latter consists, rather, of porous flakes which, like sponges, drink up liquids. Hence Pablum can be entirely saturated by the digestive secretions. This is borne out by studies of Ross and Burrill who found that the starch of Pablum is more rapidly digested than that of ordinary cereals cooked 4 hours.



140 X. STAINED (INSET) 290 X. STAINED

Large photomicrograph: Pablum mixed with cold water—portion of large flake. Pablum flakes are honeycombed with "pores" or air-spaces (note light areas A). This porosity permits ready absorption of digestive fluids by the entire flake. No starch granules are visible—they have been completely ruptured.

Inset: Farina cooked ½ hour—clump of cereal composed of unruptured starch granules. Note density of clump and lack of porosity. Many starch granules, such as are present in raw cereal, remain unchanged in form.

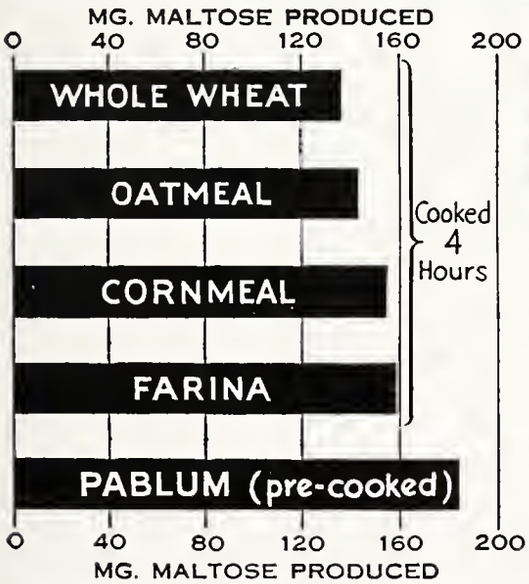


***Chart shows that maltose production is much greater for Pablum prepared with cold water than for other cereals cooked 4 hours. Ross and Burrill (Journal of Pediatrics, May 1934) conclude from this and from the total soluble carbohydrate formed that starch digestion of Pablum is more rapid than that of 6 other cereals.**

BESIDES being thoroughly cooked and readily digestible, Pablum supplies essential vitamins and minerals, especially vitamins A, B, E, and G, and calcium, phosphorus, iron, and copper. It is a palatable cereal consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, and salt.

**Reprint of Ross and Burrill paper sent on request of physicians.*

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(Continued from Page 18)

was found on the seat, with six tablets missing. In this case the driver finally must have been overcome, but awakened when his truck scraped against a guard rail. Footprints in the snow indicated that he got out and walked twice around the truck; then apparently believing that he had been asleep climbed back into the cab, closed all the windows but left the engine running to furnish heat, as it was an exceedingly cold night. He parked the truck off the edge of the road with the intention, it is believed, of sleeping until morning, but he never woke up.

In another instance children were made ill in a school bus. Investigation failed to show any leakage of gas from the engine, but carbon monoxid was detected in the rear of the bus, evidently due to eddies from the exhaust pipe. This condition was eliminated by extending the exhaust pipe beyond the rear axle and bending the end down. Streamlining tends to carry the exhaust gas away from the car.

Numerous other instances could be quoted, but enough has been said to indicate the need for a greater appreciation of the danger from carbon monoxid in closed cars, buses and truck cabs, and for more care in keeping the exhaust system in good repair. Even in cars showing no leaks there is always some carbon monoxid thrown off from the "breather" pipe unless, as in some of the newer cars, the outlet of the pipe is carried beneath the bottom of the motor so that the gas from the crank case will be swept away by the rush of air. In the majority of cars the breather pipe is on the same side as the driver's seat and, consequently, some of the gas can easily find its way into the car through the space around the pedals and steering post even if there are no cracks in the floor boards. Pieces of inner tube cut to fit about the apertures and a lining under the mat will solve most of these troubles.

Exposure to Small Amount of Carbon Monoxid for a Long Period Is Very Dangerous

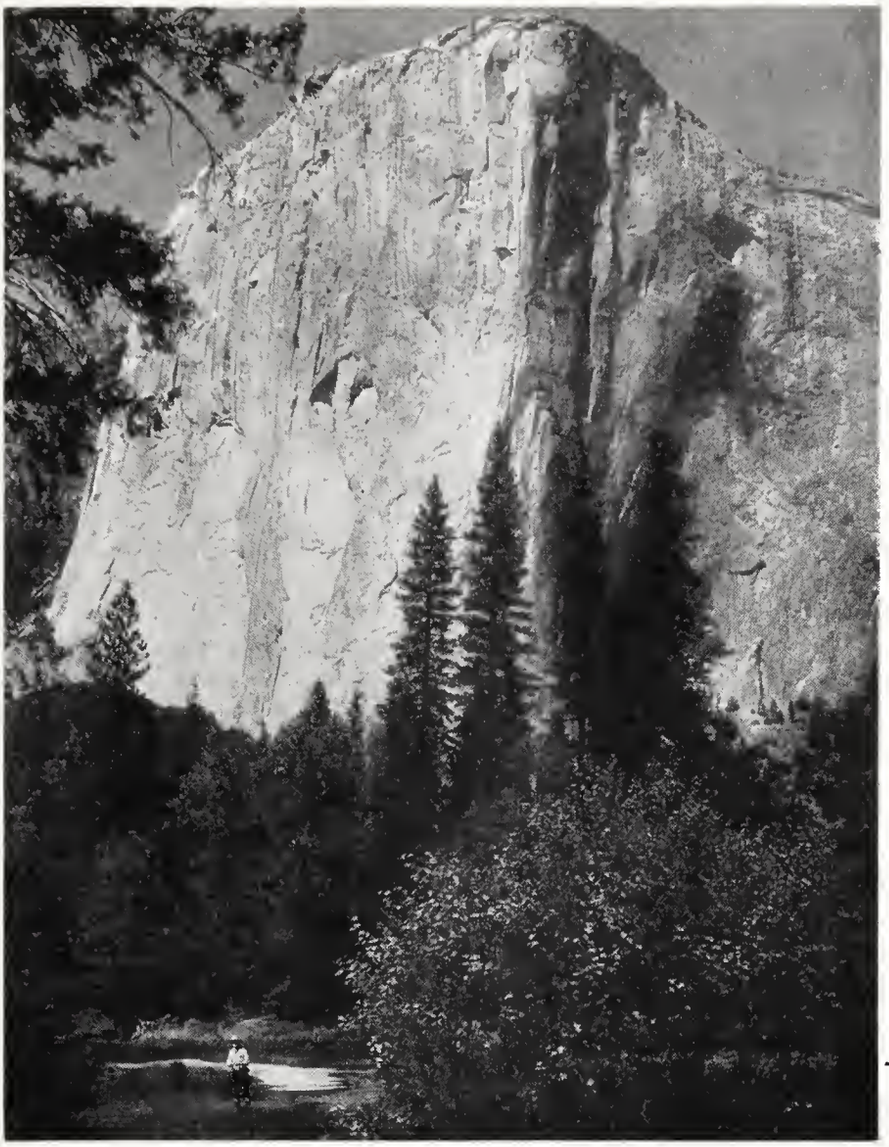
Fifteen parts of carbon monoxid in 10,000 parts of air is considered extremely dangerous, if breathed for one hour. (This is a dilution of only .15 per cent.) Numerous tests and experiments have proved this. Exposure to a small amount of carbon monoxid for a long period of time is equally as dangerous as a short exposure to a large amount. Collapse usually occurs when the parts of carbon monoxid to 10,000 parts of air multiplied by the hours of exposure equal 15.

The Department offers the following suggestions as a guide to safer winter driving:

1. Always drive with at least one window partially open for ventilation. With the newer "no draft" system of ventilation a partial vacuum is developed inside the car which tends to suck air from under the hood. Such cars need more than one window open.
2. On long trips it is an excellent rule to drive fifty-five minutes of any hour and then get out of the car and stretch and exercise for five minutes. In the long run, this "lost" five minutes can easily be made up while the ride itself will be made more enjoyable and safer.
3. Close all apertures in floor boards.
4. A periodical inspection of the exhaust system is good insurance. A new gasket is cheaper than a casket.
5. Become carbon monoxid conscious before you become carbon monoxid unconscious.

"It seems futile to attempt to reform education apart from the physical condition of the child; it seems unreasonable to expect healthy adolescence if we continue to neglect the remedy of the physical disabilities of childhood and the prevention of their cause."—Sir George Newman.

He sleeps well who knows not that he sleeps ill.—Maxim.



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Under the supervision of the National Park Service, representing the United States Public Health Service, bacterial counts are regularly taken from the milk supplies, drinking water and swimming pools throughout the Park. At Lewis Memorial Hospital, in Yosemite Valley, modern medical and dental services are always available.

We will be glad to send you details, at any time, concerning special accommodations, rates, attention to individuals, etc. Please address Don Tresidder, M. D., President, Yosemite Park and Curry Co., Yosemite National Park, California.

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An approved clinical pathologist should be a licensed graduate of medicine. He sball have specialized in clinical patbology, bacteriology, pathology, chemistry, and other allied subjects for at least tbree years, and he should be reasonably familiar with the manifestations of disease in the body. Tbe director of a clinical laboratory sball be on full time or bave definite bours of attendance, devoting tbe major part of his time to tbis specialty. A clinical laboratory is an institution organized for tbe practical application of the fundamental sciences by the use of specialized apparatus, equipment and metbods, for tbe purpose of ascertaining tbe presence, nature, source, and progress of disease in tbe human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

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Venereal Diseases and Food Handlers.—New York *Health News* prints the following:

QUESTION: (1) How common is the spread of venereal disease through food handlers? (2) Are there any definite proved cases of syphilis which have been transmitted by food handlers? (3) If cases are under treatment are they permitted to work as cooks and waiters?

ANSWER: (1) There is no scientific evidence that syphilis and gonorrhea are commonly spread by infected food handlers. It is conservatively estimated that approximately 7 per cent of syphilis is contracted extragenitally. Most of the extragenital chancres appear around the lip and are probably due to kissing. The spirochaetes are very feeble organisms and do not persist for many hours under conditions usually prevailing outside the body.

(2) An extensive review of the literature shows only a few cases of syphilis reputed to have been acquired from food handlers. However, syphilis when acquired in restaurants may easily be due to actively infected customers rather than to employees.

(3) If cases of syphilis are under intensive arsphenamin treatment, after a minimum of two or a maximum of four, they are not usually a menace to the public and should be permitted to work even as cooks or waiters, provided they receive continuous, uninterrupted treatment.

The State does not encourage local ordinances requiring physical examinations of food handlers. Such examinations have a popular appeal, but little if any demonstrated value in preventing the spread of syphilis or gonococcal infections.

QUESTION: How much authority and responsibility does the local health officer have for the water supply of a factory located in our town?

ANSWER: Regulation 4, Chapter V of the Sanitary Code, places the jurisdiction of such water supplies upon the local health officer.

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Mortality in California.—The following discussion of mortality is from the biennial report of the Division of Vital Statistics:

The number of deaths registered during the calendar years 1932-1933 is 135,614 as against 133,691 during the preceding biennium. For individual years the numbers are: 1933, 67,992; 1932, 67,622; 1931, 67,513; and 1930, 66,178. Corresponding rates are 11.2, 11.3, 11.5 and 11.5 deaths per one thousand population. Deaths have occurred in every county of the State in 1932, but in Alpine County with its 241 estimated population, we find no deaths in 1933.

Deaths by race reveal the expected distribution. Of course whites predominate, with Mexicans second and negroes third. Table H gives the deaths by racial groups, both as to numbers and per cent for the two calendar years covered by this biennial report.

TABLE *H—Deaths by Race, 1932 and 1933*

	1932		1933	
	Number	Per Cent	Number	Per Cent
All races	67,622		67,992	
White	59,205	87.6	59,803	88.0
Negro	1,310	1.9	1,367	2.0
Indian	334	0.5	314	0.5
Chinese	633	0.9	590	0.9
Japanese	696	1.0	693	1.0
Mexican	5,014	7.5	4,779	7.0
Other	430	0.6	446	0.6

When it comes to an analysis of deaths by the nativity of the deceased, we find more deaths of foreign born than there are deaths among persons born in California. This holds true for every year, and comparisons are given in Table I for the past four years.

(Continued on Next Page)

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(Continued from Preceding Page)

TABLE *I—Deaths by Nativity, 1930-1934, Inclusive*

	1930	1931	1932	1933
Total	66,178	67,513	67,622	67,992
California	15,517	15,321	14,707	14,935
Other United States	30,806	31,896	32,720	33,135
Foreign born	18,625	19,062	19,005	18,760
Unknown	1,230	1,234	1,190	1,162

When we compare deaths in different age groups we find that those one year of age are responsible for approximately 6.5 per cent of the total deaths. The percentage then drops in the age groups 1 to 4 and 5 to 14 and begins to rise steadily until those who die at age 65 or over contribute about 40 per cent of the deaths. There is also a difference between the two biennia. In 1930-1931 the lower age groups contribute a larger proportion of deaths than in the years 1932 and 1933, while in the latter period the older age groups are responsible for more. Table J gives these figures in detail, with the percentage of total population in each age group in 1930.

Diseases of the Circulatory System

Deaths from these causes continue to increase through this biennium as through previous periods. As a matter of fact, there has been a steady and almost uninterrupted increase among these causes since State registration was established, as shown in Table K.

TABLE *K—Deaths from Diseases of the Circulatory System 1906-1933, Inclusive*

Year	Number	Rate per 100,000
1906	3,766	185.1
1907	4,362	205.2
1908	4,540	204.9
1909	4,966	215.4
1910	5,087	212.0
1911	5,516	219.9
1912	6,376	243.7
1913	6,281	230.6
1914	6,397	225.8
1915	7,251	246.6
1916	8,040	263.7
1917	7,483	237.0
1918	7,020	215.0
1919	7,773	230.4
1920	8,013	226.6
1921	8,370	222.9
1922	9,204	231.6
1923	9,632	229.7
1924	10,572	239.6
1925	11,262	243.2
1926	12,254	252.6
1927	13,571	267.7
1928	14,815	280.1
1929	15,620	283.6
1930	16,176	282.2
1931	17,027	291.2
1932	17,681	297.3
1933	18,647	307.6

TABLE *J—Deaths by Age Groups, by Two-Year Periods, 1928-1933*

Age Group	Two-year Period 1928 and 1929		Two-year Period 1930 and 1931		Two-year Period 1932 and 1933		Population, 1930 Federal Census	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
	131,612	100.0	133,691	100.0	135,614	100.0	5,677,251	100.0
Under 1	10,359	7.9	9,554	7.1	8,147	6.0	76,319	1.3
1-4	3,859	2.9	3,647	2.7	2,687	2.0	329,048	5.8
5-14	3,243	2.5	3,161	2.4	2,774	2.0	889,520	15.7
15-24	6,435	4.9	6,084	4.5	5,382	4.0	903,811	15.9
25-34	8,876	6.7	8,240	6.2	7,895	5.8	978,693	17.3
35-44	12,335	9.4	11,781	8.8	11,611	8.6	932,119	16.4
45-54	16,290	12.4	17,137	12.8	17,485	12.9	725,026	12.8
55-64	20,707	15.7	21,757	16.3	23,029	17.0	462,851	8.2
65 and over	49,508	37.6	52,330	39.2	56,604	41.7	366,125	6.4

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Deaths from circulatory system diseases have constituted an increasingly greater percentage of total deaths over the period of years covered. In 1906 they make up 12.8 per cent of the total deaths; in 1910, 15.7 per cent; in 1915, 18.6 per cent; and in 1920, 17.0 per cent. Since 1920 the percentage of toal deaths has steadily increased, as shown in Table L, until during the year 1933, when 27.4 per cent are due to circulatory system diseases.

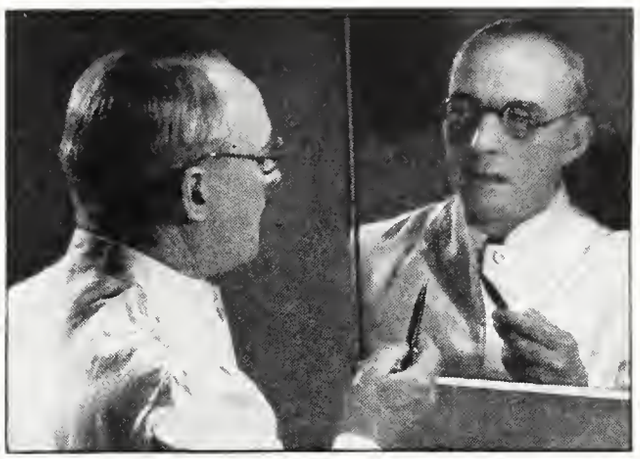
TABLE *L—Percentage of Total Deaths Due to Circulatory System Diseases 1920-1933, Inclusive*

Year	Total Deaths	Circulatory System Disease Deaths	Per Cent
1920	47,124	8,013	17.0
1921	47,379	8,370	17.7
1922	51,968	9,204	17.7
1923	54,416	9,632	17.7
1924	56,751	10,572	18.6
1925	56,707	11,262	19.8
1926	58,742	12,254	20.9
1927	61,430	13,571	22.1
1928	66,249	14,815	22.4
1929	65,363	15,620	23.9
1930	66,178	16,176	24.4
1931	67,513	17,027	25.2
1932	67,622	17,681	26.1
1933	67,992	18,647	27.4

During the last three years deaths from pericarditis, endocarditis, and angina pectoris have shown a decrease, while those from myocarditis, diseases of the coronary arteries, aneurysm (except of the heart) and arteriosclerosis have all shown increased numbers. This may indicate a tendency which is being shown, or it may be simply a fluctuation, especially among those cases where there is a decrease. Comparable figures are given for each of the causes under this cause group in Table M.

(Continued on Next Page)

Please give yourself this good advice, Doctor



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(Continued from Preceding Page)

Table *M—Individual Causes of Death from Circulatory System Diseases, California 1931-1933, Inclusive*

Int'l list Number	Cause of death	1931	1932	1933
	Circulatory system diseases	17,027	17,681	18,647
90	Pericarditis	65	52	45
91A	Endocarditis, specified acute	267	236	220
91B	Endocarditis, unspecified (45 years and under)	9		
92	Chronic endocarditis	2,901	2,820	2,772
93A-B	Acute myocarditis	250	254	262
93C-D	Chronic myocarditis	8,428	8,806	8,856
94A	Angina pectoris	1,126	1,060	1,026
94B	Diseases of the coronary arteries	1,263	1,590	2,292
95	Other diseases of the heart	895	859	1,132
96	Aneurism (except of heart)	199	260	304
97	Arteriosclerosis	1,461	1,605	1,600
98	Gangrene	21	14	14
99	Other diseases of the arteries	103	77	78
100	Diseases of the veins	25	37	32
101	Diseases of the lymphatic system	5	9	5
102	Idiopathic diseases of the blood pressure	4	1	4
103	Other diseases of the circulatory system	5	1	5

Analysis of deaths from circulatory system diseases by age groups shows no startling change from the previous biennium. The younger age groups show comparatively few deaths, but they increase very heavily after age forty-five. This is to be expected, since this group is one of the chief factors in causing the death of elderly people. Detailed analysis of circulatory system deaths by age group is given in Table N.

Table *N—Deaths from Diseases of the Circulatory System by Age Groups, California 1930-1933, Inclusive*

	1930	1931	1932	1933
All ages	16,176	17,027	17,681	18,647
Under one year	10	15	2	
1-4	15	14	6	14
5-14	72	58	57	56
15-24	150	174	163	133
25-34	297	311	278	292
35-44	798	809	761	793
45-54	1,739	1,873	1,870	2,030
55-64	3,121	3,279	3,422	3,715
65 and over	9,974	10,494	11,122	11,614

Cancer

Cancer is another of the degenerative diseases, and is a constantly increasing factor in the number of deaths in California although in the last four years the death rate per 100,000 estimated population has remained nearly stationary. There were 7,451 deaths

(Continued on Page 28)

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Laryngoscope, 1935, XLV, 149-154★

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

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(Continued from page 26)

from this cause in 1932, with a rate of 125.3 per 100,000 estimated population and in 1933, 7,677 deaths with a rate of 126.6. These may be compared with the figures for 1930 and 1931, with 7,195 and 7,411 deaths and 125.5 and 126.7 per 1,000 estimated population, respectively. Rates for 1931, 1932, and 1933 are purely provisional and may be changed when population figures are released after the next federal census. Table O gives the deaths from cancer, with corresponding rates, for California from 1906 to 1933, inclusive.

TABLE *O—Deaths from Cancer, California 1906-1933, Inclusive*

Year	Number	Rate*
1906	1502	73.8
1907	1590	74.8
1908	1737	78.4
1909	1945	84.5
1910	1984	82.8
1911	2029	80.9
1912	2306	88.1
1913	2565	94.2
1914	2687	94.8
1915	2776	94.4
1916	2879	94.4
1917	3085	97.7
1918	3199	98.0
1919	3519	104.3
1920	3780	106.9
1921	4025	107.2
1922	4484	112.8
1923	4702	112.1
1924	5114	115.9
1925	5278	114.0
1926	5638	116.2
1927	5927	116.9
1928	6403	121.0
1929	6518	118.3
1930	7195	125.5
1931	7411	126.7
1932	7451	125.3
1933	7677	126.6

* Number of cancer deaths per 100,000 population.



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Inspection of the above table shows that, while there is an increase in actual numbers, the rates have been fairly stationary for the past four years. There is a total of 14,606 deaths from cancer during 1930 and 1931, while during the following biennium there are 15,128 such deaths. When the biennial rates are calculated, we find that for 1930 and 1931 the rate is 126.1 hundred thousand estimated population, while in 1932 and 1933 the rate is 126.0. This is the first time that there has been a stationary rate for deaths from cancer in two consecutive biennia. This is shown in the following table:

TABLE *P—Biennial Rates for Cancer Deaths 1920-1933, Inclusive*

Biennium	Number	Estimated Population	Biennial Rate
1920-1921	7,805	7,293,000	107.0
1922-1923	9,186	8,171,000	112.4
1924-1925	10,392	9,049,000	114.8
1926-1927	11,565	9,927,000	116.5
1928-1929	12,921	10,806,000	119.6
1930-1931	14,606	11,580,000	126.1
1932-1933	15,128	12,000,000	126.0

There seems to be a leveling off in the cancer death rate which may indicate that we have reached a point where appreciable increases in the ratio may not occur. As it is, during the last biennium, about one in every nine deaths is caused by cancer.

Cancer during these two years shows the usual distribution according to sex as there are more deaths among females than among males. Out of the 7,677 cancer deaths in 1933, 4,054 were females and 3,623 males. In 1932 there was approximately the same proportion, for of 7,457 cancer deaths 3,978 were females and 3,473 were males.

Table F shows that 88.8 per cent of the population in 1930 are whites, and yet an analysis of cancer deaths by race shows that 94.1 per cent of such deaths are among people of the white race. It may be that people of the white race have a longer average life span, although figures to prove this are not available, and if so would account for the higher percentage of cancer deaths among whites.

The number of deaths from cancer classified as to site of the primary growth shows some variation among the different sites. There is an increase over the previous biennium in cancers originating in the digestive tract and peritoneum, in cancers of the female genital organs, cancer of the breast and cancers in organs other than in special sites listed separately and of unspecified location. Some of these increases are slight in number, as is the decrease among cancers of the buccal cavity and pharynx and cancers of the skin.

(Continued on Next Page)

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CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
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(Continued from Preceding Page)

The total number of cancers in the last two biennia and distribution according to the site of the primary lesion is shown in Table Q.

TABLE *Q—Cancer According to Site of rimary Lesion 1930 and 1931, 1932 and 1933*

Site	Biennium 1930-1931	Biennium 1932-1933
Cancer, all locations	14,606	15,128
Buccal cavity and pharynx	503	496
Digestive tract and peritoneum	6,851	7,166
Female genital organs	2,002	2,104
Breast	1,519	1,619
Skin	320	306
Other organs and unspecified	3,311	3,437

Massage Administered by Quacks May Result in Serious Injury.—Temporary injury and even irreparable damage have resulted, in countless instances, from the unwise application of massage by untrained hands, according to Dr. Maurice F. Lautman, who discusses massage as distinguished from mauling. The apparent harmlessness of massage, coupled with the fact that its use is so frequently exploited by untrained laymen in gymnasiums and beauty parlors, as well as by quacks of the "drugless" variety, has given rise to the impression that if massage does no good, at least it can do no harm. This idea is far removed from the truth.

Women who wish to reduce "in spots" are often willing victims of violent massage treatments. They have been convinced by the argument that even if they do not reduce in weight they will lose in inches, and that the mauling is beneficial in "breaking up the fat." Violent abdominal massage has been the cause of cases of uterine displacement and recurrence of quiescent gall-bladder and appendix difficulties.

On the other hand, massage is exceedingly useful in the treatment of arthritis and rheumatism. It is also of great benefit to persons who have been confined to bed by illness for a long time and to persons whose limbs or muscles are wasting. In cases of sprain, careful massage will hasten the disappearance of the swelling.

The Treatment of Syphilis—Charts (price 30 cents) prepared by the American Social Hygiene Association, 50 West Fiftieth Street, New York, N. Y., present a study of eight thousand cases by Johns Hopkins University, The Mayo Clinic, University of Michigan, University of Pennsylvania, Western Reserve University, in coöperation with the United States Public Health Service:

CHARTS

1. Mucocutaneous relapse during lapse of treatment, according to stage in which treatment was begun.
2. A. Site of mucocutaneous relapse lesions. B. Time relation of mucocutaneous relapse.
3. Comparison of treatment in 204 mucocutaneous relapses.
4. Relation of arsphenamin to the prevention of mucocutaneous relapse.
5. The sites of secondary lesions in 2,269 patients.
6. Incidence of early asymptomatic neurosyphilis.
7. Incidence of asymptomatic neurosyphilis according to stage of disease in which treatment was begun.
8. Relation of blood Wassermann fastness to spinal fluid abnormalities in early syphilis.
9. Positive darkfield examinations by stages of early syphilis.
10. Treatment methods.
11. Comparative effectiveness of treatment methods.
12. Comparison of effectiveness of treatment methods in securing Wassermann reversals in one year.
13. Effect of prolonged treatment on satisfactory results.

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15. The value of x-ray of the cardiovascular stripe in clinically latent syphilis.
16. The prognostic value of negative spinal fluid in latent syphilis.
17. Frequency of symptomless infection.
18. Outcome of pregnancy in untreated latent syphilis.
19. Effect of treatment of syphilitic pregnant women with negative Wassermanns.
20. Effect of treatment of syphilitic pregnant women.
21. Results of treatment in latent syphilis, continuous versus intermittent or irregular treatment.
22. Results of treatment in latent syphilis by gross amount of treatment given.
23. Results of treatment in latent syphilis according to the total length of observation.
24. Influence of Wassermann fastness on the tendency toward clinical relapse.

On Training the Mind.—Are you able to swim? How few swim well! With noisy splashing one man manages to propel himself a few feet before making a forced landing; another with graceful motions goes far. By mastering the technique of a good stroke we apply our strength effectively and, as the captains of the submarines say, "have good cruising range." Powers of this kind arise from training and practice.

Similarly, all people use their minds, but how few use them well! Few are capable of sustained thinking, and so following a chain of evidence to a sure conclusion. Such powers result from training and practice.

But if the ingredients of a good intellect be not within us, how shall we become wise? Fortunately, to desire the things of the spirit is itself evidence of endowment. One should try to form good mental habits. Herein the will comes into play. A common experience is to undertake a line of work and presently to find oneself growing fond of it. With few exceptions, what we will to do, we eventually like to do. Then, with the doing, we begin to acquire skill. Power, whether mental or physical, is gained in part through suggestion or imitation. We should, therefore, have before us good models. So, the man who aspires to make the most of his mind will do well, as opportunity offers, to associate with persons of promise, of ability, and originality. If he finds such persons scarce, he may come to know many through their works, through the books they have written, the pictures they have painted, and the songs they have sung. While association gives inspiration, the essential work in this field must be done by the man himself for himself.

No enterprise in the wide range of human experience can rank with training the mind. If, therefore, we have received from heaven nothing so good as the mind, what should be more worthy of exercise and cultivation? No other adventure is to be compared with it. Through it civilization and all man's higher achievements have been won. The report of a gun does not carry so far as the music of the lyre. To pursue intellectual ideals, unlike the privilege of galloping with a king in a royal game park, is a glorious adventure open to every man who cares to live richly and well.—Professor Leon J. Richardson, University of California Extension Division.

"Dressing Up" Game Develops Dramatic Sense.—The game of "dressing up" stimulates the dramatic sense in children and eventually teaches them to write their own plays, according to Sophia Yarnall.

Besides making children feel unself-conscious before an audience, it should give them a new appreciation of the theater and an interest in the color and design of clothes, and should enhance their pleasure in literature and give them an idea of the literary as well as the dramatic quality of a play.

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1935

CALIFORNIA AND WESTERN MEDICINE

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SALUTATION FROM PRESIDENT TOLAND

Greetings to the Members of the California Medical Association:

The Officers and Council of the California Medical Association extend their greetings to all members and their friends expecting to accompany them to the Yosemite:

In the hope that each member may be able to induce at least one fellow physician, alike eligible for membership, also to attend in May the meeting of such prospective interest and importance.

All that has been accomplished during the last five years for advancement and benefit of scientific medicine in this great State of ours has been as advantageous to each and every person qualified to join the Association, as it always has proved to be for the thousands already members.

This carefully planned meeting for 1935, with its well-prepared and inviting programs, gives every promise of becoming a great success: already a month ago five hundred reservations or more were registered at the various hotels in the Yosemite, and each day now still brings new requests for accommodations.

Therefore, *please come!*

CLARENCE G. TOLAND, *President*

THE PROBLEM OF PROSTATISM

SUPRAPUBIC OR PERINEAL PROSTATECTOMY VERSUS TRANSURETHRAL RESECTION, AND GLANDULAR THERAPY VERSUS OPERATION OF ANY KIND

By Frank Hinman, M.D.
San Francisco

THE man with an enlarged prostate chooses his surgeon through having been referred to him, or on account of his renown in this field. As a rule, the patient has no choice of treatment in mind and no ideas regarding the method by which he should be treated. He accepts the advice of the surgeon he has chosen and subsequently is operated on either suprapubically or perineally, or resection is done transurethrally according to the particular bias of his surgeon. On the other hand, the doctor who referred him may have been influenced by a personal bias of his own toward the suprapubic, perineal or transurethral method, and not infrequently the patient himself has thought over the advisability or necessity of operation, has talked this over with doctors, relatives and friends, and has been influenced by his own opinion of the three methods to choose a surgeon who is known to favor the suprapubic, perineal or transurethral route. The biased opinions of relatives, doctors and patients, about enlarged prostates, are based on what they have heard, seen and read. The opinions of the urological surgeons who favor the suprapubic, the perineal or the transurethral operation, are based largely on the way they were trained, or on what they have learned along the hard road of personal experience.

REASONS FOR DIFFERENCES OF OPINION

It is rather unusual that such marked differences of opinion should have persisted so long and that there should have been such a prolonged controversy over the choice of one of these two methods of open operation: suprapubic or perineal. There can be no question of the honesty and sincerity of the opposed surgeons. However, neither can there be a question that, in the heat of argument, they are often unfair to each other; and it is this unfairness, altogether unintentional, which gives the inaccuracy to the biased opinion of doctors, relatives and patients. Within recent years, the controversy reached a certain level of agreement, namely, each group was willing to say to the other: "Do the operation the way you yourself can get the better results." This is by no means a satisfactory solution because, if one method is safer and better than the other, every urologist should learn to operate by this safer and better route, irrespective of his training to the contrary.

NEWER METHODS OF TRANSURETHRAL RESECTION

Within the last few years, newer methods of transurethral resection have been perfected and have reopened the wounds of controversy. In this renewed dispute, the advocates of the suprapubic and of the perineal operation have agreed to take sides jointly against the radical resectionists. Transurethral resection, at the outset, was heralded as another remarkable triumph of the urologist in the treatment of prostatic enlargement. Open operation was expected to disappear with the passing of the "old timers," and the newer generation would know no other method than transurethral resection. Prostatectomy was to become a simple procedure, accomplished through the urethra, which could be done in the office without risk, without preparation and without prolonged hospitalization. As for most innovations, too much was claimed for it. It is now just beginning to reach its true level of usefulness in comparison with suprapubic and perineal prostatectomy.

CONTROVERSY REMAINS UNSETTLED

The old controversy remains unsettled. Comparisons between a mortality of over 40 per cent by the use of the suprapubic method and less than 4 per cent by the perineal operation appeared recently, and the arguments were presented anew in the controversial correspondence* between Keyes, who uses the suprapubic operation, and Young, who uses the perineal. To quote the former:

> "Surely no one would prefer a two-stage suprapubic prostatectomy, even the modern, clean operation, with its longer hospitalization and correspondingly higher mortality, to the beautiful dissection of which Doctor Young is master—except for the fact that in other than the most skillful hands the perineal operation is too uncertain. We present our regrets to Proust, to Albarran, to Wildbolz, to Hinman, to all the other honest gentlemen who have labored so well between 'wind and water.' They have opened a delightful operative field which, with the disappearance of perineal prostatectomy, vesiculectomy, radium implantation, threatens to become a lost region."

With all due respect and friendship, I must disagree with this broad generalization of Doctor Keyes. How many men who have the skill and courage to operate by way of the perineum have deserted this route, which they know to be safer and better, for the uncertain one of transurethral resection? So far as I know, there has not been one. Several surgeons who were known to favor the suprapubic route, however, now advocate resection for all types of cases, and this fact alone is some proof of the superiority of the perineal route. I wish to agree with Doctor Young, and I am sure all those other men who have learned to operate by way of the perineum also agree with him, when he says (to quote from the foregoing correspondence):

> "If perineal prostatectomy is doomed, along with it will go other perineal operations, such as those for cancer of the prostate, stones in the prostate, ruptures of the prostatic urethra, cysts of the prostate, abscesses and tuberculosis of the prostate, and seminal vesicles and many other rarer conditions, which can be accurately attacked only through the perineum."

Even if urologists went to the extreme which Doctor Keyes predicts, and eliminated the perineal route for the enlarged prostate (this possibility seems imminent on account of glandular therapy

* Jour. Amer. Med. Assoc., 103: 1085-1088, Oct. 6, 1934.

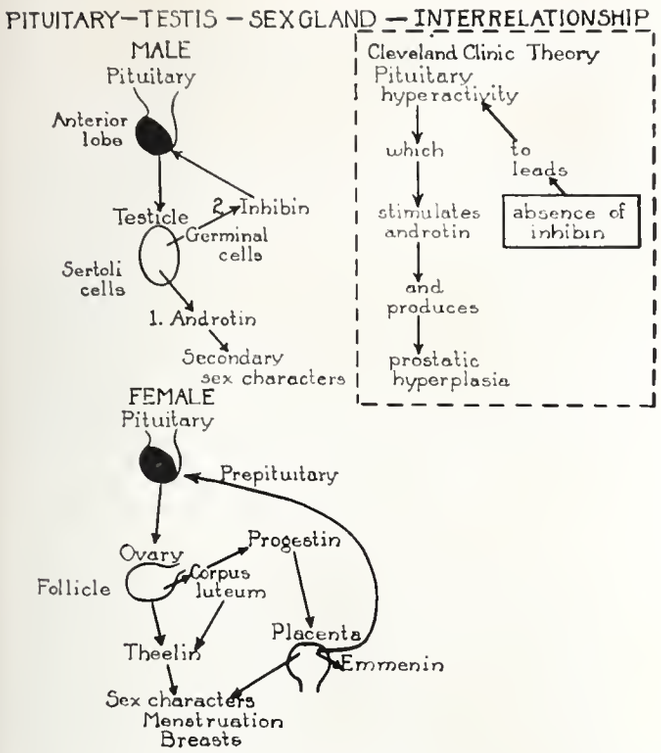


Chart 1.—Diagrammatic representation of the interrelationship between the pituitary gland and the testis, and a diagram of the homologous relationship in the female for comparison. In the right corner is a diagrammatic representation of the theory of causation of prostatic hyperplasia.

in the offing, which certainly would also eliminate the suprapubic route), the urologist, trained and skilled in the use of this route, would still give his patient better service for these other conditions than the men not so trained.

A POLL OF POINTS OF VIEW OF TWENTY UROLOGISTS

On February 22, 1935, a verbal poll of the twenty urologists—representing Montreal, Boston, New York, Philadelphia, Baltimore, Cleveland, Indianapolis, Chicago, Rochester, St. Louis, and Iowa City—attending a clinical meeting in Cleveland, showed that, with four exceptions (none of whom used the perineal operation before transurethral resection became popular), all preferred and practiced open operation, either suprapubic or perineal, for the removal of large prostates. It was recognized by all, however, that the newer method of transurethral resection is a distinct advance in the treatment of early single enlargements, median bars, commissural lobes, etc., conditions which formerly also were not operated on by the open method, but were treated, as a rule, by the punch procedure of Young. This attitude of the majority of the urologists at this meeting reflects the general experience with transurethral resection of the urologists of this country as a whole. Each, in his own way, has learned that the transurethral resection of a large prostate is a major operation and cannot be done as an office procedure; that it carries more risk of death than open operation, particularly if this is done by way of the perineum; that the immediate results are complicated by secondary hemorrhage, infections and urinary disturbances often requiring a second-stage resection; and that the late results are by no means permanent, patients returning in increasing numbers in two, three or four years with recurrent prostatism. Personal experience of this kind has led the conservative urologist to relegate resection to its proper sphere. In spite of the glowing accounts of a few enthusiasts, he recognizes the fact that transurethral resection is not a method to be used universally for all types of prostatism. Of necessity, there are borderline conditions in which it is an open question whether the patient should be resected or operated upon, and then it is a matter of personal choice of the physician and patient.

APPLICATION OF NON-OPERATIVE PROCEDURES

For these borderline patients, and possibly for all patients with simple hyperplasia, there appears on the horizon of clinical medicine a fourth method of treatment which will please the patient more than the surgeon. It will please the patient because it is medicinal and non-operative. There will be no hospitalization and no incidental expenses. (It may be said in passing, however, that this method will leave the perineal route triumphant over the suprapubic, because the former will still be used to treat cancer, tuberculosis, calculi, etc.). The new method is one of glandular therapy and is neither standardized nor entirely proved. Like transurethral resection and all new things with great promise, it may prove a disappointment. It is based on the work of the Cleveland Clinic, particularly that of Lower and McCullagh.

THE MALE SEX HORMONES: ANDROTIN AND INHIBIN

The testis forms two hormones, androtin and inhibin. Androtin is the male sex hormone known since Claude Bernard first demonstrated comb growth in capons after the administration of testicular extract. It controls the secondary sexual characteristics of the male. Inhibin is the name given to a hormone not yet isolated, but postulated on experimental grounds and so named by McCullagh. The future of glandular therapy in the treatment of the enlarged prostate rests upon the ultimate isolation and purification of this hormone. The soundness of the theory and the basis for optimism as to its future are attested by the following types of experiments:

When the hypophysis is removed from rats, their prostates and seminal vesicles undergo atrophy. Feeding androtin to these hypophysectomized rats restores the prostates and vesicles to normal. The water soluble (alcohol and acetone insoluble) thermolabile substance of the testis, which McCullagh has called inhibin, has no effect upon the prostate and vesicles of hypophysectomized rats.

If two rats are placed in parabiosis by connecting peritoneal cavities, and one of these rats is castrated, the prostate and vesicles of the uncastrated animal hypertrophy, and those of the castrated rat, atrophy. The theoretical explanation of this is that the gonadotropic hormone of

the pituitary of the castrated rat is abnormally increased in amount because inhibin, which limits this production, has been removed by the castration. This water soluble hormone passes over to the uncastrated animal and stimulates the testicles to form androtin, which in turn stimulates the growth of the prostate and vesicles. Androtin, being fat soluble, does not pass back through the peritoneal fluids of the uncastrated to the castrated animal, and therefore, the prostate and vesicles of the castrated animal atrophy. On the other hand, if either of these animals in parabiosis is fed inhibin, it passes from one animal to the other, since it is water soluble, and the prostate and vesicles of the uncastrated animal will atrophy.

It has been shown, experimentally, that when normal rats are fed this water soluble thermolabile hormone called inhibin, prostatic atrophy results.

This hormone, inhibin, markedly diminishes the frequency of the oestrous cycle in female rats, and reduces the ejaculatory reflex and the amount of ejaculate in male guinea pigs.

These facts may be represented diagrammatically as outlined in Chart 1.

It remains to be shown to what extent inhibin will affect a gland which has already undergone hyperplasia, and also whether there are any subsidiary effects which would endanger its extensive use clinically. It remains, also, to isolate the hormone in a purified form. Undoubtedly the discovery of inhibin opens up a vista of pleasant possibilities for the patient of the future who becomes afflicted with hyperplasia of the prostate. However true to theory it works, it will not be effective for every patient with prostatism any more than transurethral resection or perineal enucleation will be. Careful study of patients, and careful selection of the treatment best suited to each condition, must be practiced. The lines of treatment open to future urologists may be glandular therapy for hyperplasia, perineal prostatectomy and vesiculectomy for cancer, calculus, tuberculosis, some chronic infections, etc., and transurethral resection for the fibrous, commissural and median bars. (There will be no suprapubic prostatectomies.) Until this day arrives (and it may be wrongly predicted and never arrive, or it may arrive in a few years or after many years), each patient should be studied with a choice in mind between two lines of treatment, namely, open operation or resection. The patient and the doctor who refers the patient should understand that neither of these methods is suitable exclusively for all types of prostatism. Each has its respective sphere of usefulness.

IN CONCLUSION

The logical plan, therefore, at present is to select the line of treatment to fit the condition: open operation, either suprapubic or perineal, for large prostates (perineal for cancer, tuberculosis, calculi, etc.), and transurethral resection for small lobes which are obstructing, and for median bars and contractures. So-called prophylactic operations are to be condemned.

384 Post Street.

TULAREMIA IN CALIFORNIA*

By HIRAM E. MILLER, M. D.
San Francisco

DISCUSSION *by John F. Kessel, Ph.D., Los Angeles; H. A. Wyckoff, M. D., San Francisco; Clair L. Stealy, M. D., San Diego.*

TULAREMIA was first observed in 1911[1] as a plague-like disease of the California ground squirrel. The causative organism, Bacterium tularense, received its name from Tulare County where the diseased rodents were found. The long duration of the disease in man, and the subsequent disability, make tularemia of considerable economic and social importance. It was made a reportable disease in California on July 2, 1928.

CHART 1.—*Tularemia: Source of Infection*

1. *Wild rabbits* (jack, cottontail and snowshoe). Encountered by hunters, butchers, housewives, etc.
2. *Woodticks* (Dermacentor andersoni, Stiles). Transmit infection from rabbits to man and are a permanent source of infection because of hereditary transmission of infection through eggs.
3. *Flies* (Chrysopsdiscalis) (deer fly). Blood-sucking fly found on horses but also bite deer, rabbits and man.
4. Occasionally from other animals and insects.
5. Man to man infection does not occur.

Wherry and Lamb, in 1914,[2] isolated the Bacterium tularense from the first human case of tularemia. It was a patient of Vail of Ohio with conjunctivitis. Martin of Arizona,[3] in 1907, had previously called attention to undoubted cases and attributed them to "rabbit septicemia." Pearse of Utah,[4] in 1911, described six clinical cases caused by the bite of the deer fly. Francis,[5] in 1919-1920, recognized that deer fly fever, rabbit septicemia and plague-like disease of ground squirrels are all the same disease.

CHART 2.—*Tularemia: Source of Infection in California Cases*

	Cases
Insect bites	9
Contact with rabbits	68
Coyote bite	1
Cut on chicken bone	1
Knife cut	1
Laboratory infections	3
Unknown	5
Total	88

DISEASE IN ANIMALS

Wherry and Lamb, in 1914,[2] discovered that wild rabbits were the chief source of human infection. They prophesied that there would be a steady increase in the number of patients observed with this disease. The infection in the California ground squirrel is not a source of human infec-

*From the Division of Dermatology, University of California Medical School and the Dermatological Service of the Southern Pacific Hospital.

Read before the General Medicine Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

CHART 3.—*Cases of Tularemia by Counties and Years, 1927 to Date. From the Records of the California State Department of Public Health*

Counties	1927	1928	1929	1930	1931	1932	1933	1934*	Total
Alameda	..	..	1	..	..	..	..	..	1
Del Norte	..	..	..	..	1	..	..	..	1
Fresno	..	..	..	..	..	..	3	..	3
Imperial	..	..	..	3	..	1	..	..	4
Kern	..	1	8	5	..	1	..	..	15
Kings	..	..	..	2	2	..	1	..	5
Lassen	..	..	1	..	..	2	..	..	3
Los Angeles	..	1	..	..	..	..	2	..	3
Marin	..	..	..	..	2	..	..	..	2
Mendocino	..	..	..	1	..	..	..	..	1
Merced	1	..	..	..	..	2	..	..	3
Modoc	..	3	1	..	..	..	..	..	4
Monterey	..	..	1	1	..	..	1	..	3
Orange	..	..	1	..	..	..	..	..	1
Plumas	..	..	1	..	..	..	1	..	2
Riverside	..	..	..	..	..	..	..	1	1
Sacramento	2	..	..	..	..	..	..	..	2
San Bernardino	..	..	1	..	..	..	1	..	2
San Diego	..	3	1	..	..	1	..	..	5
Santa Clara	..	..	..	..	1	..	..	..	1
San Benito	..	..	1	..	..	..	..	..	1
Siskiyou	..	..	1	..	..	..	1	..	2
Sonoma	..	..	..	..	..	..	1	..	1
California†	..	11	2	2	4	1	2	..	22
Totals	3	19	20	14	10	8	13	1*	88

* To date.
† This classification used for those cases contracted outside of California, but diagnosed in this State.

tion, as these rodents are not hunted or eaten. Meadow mice, wild rats, coyotes, gophers, birds, and, in fact, a large number of animals are occasionally infected. Chart 1 shows the part played by the wood tick and deer fly in transmitting the disease.

Chart 2 reveals that the infection in 75 per cent of the California cases was acquired from wild rabbits, and in 10 per cent from insect bites.

DISEASE IN MAN

The California State Department of Public Health reports eighty-eight[6] cases of tularemia in California from 1927 to March 14, 1934. The following chart shows the distribution of these cases by counties. It is of interest that Kern County had many more cases than any other county, and that the disease was much more prevalent in Northern than in Southern California. (Chart 3.)

I have seen, in private practice, two patients with tularemia, and have observed eleven additional cases on the medical service at the Southern Pacific Hospital. (Figs. 1 and 2.) Most of these patients acquired the disease in Nevada.

The disease in man occurs in three forms: 1. *Ulceroglandular.* The primary lesion occurs on the skin as a papule that soon ulcerates. It is accompanied by enlargement of the regional lymph nodes. 2. *Oculoglandular,* with conjunctivitis and an associated regional glandular involvement. 3. *Typhoidal,* without a primary lesion or glandular involvement.

CHART 4.—*Tularemia: Clinical Course*

1. *Inoculation of B. tularense* from animal, insect or laboratory source.
2. *Incubation period,* one to ten days. Average, three days.
3. *Symptoms* start suddenly generally while patient is at work. Headache, vomiting, chills, fever, prostration.
4. *Fever*—Initial rise to 103 degrees Fahrenheit for one to three days. Remission for one to three days. Secondary rise with gradual fall. Fever remaining for three weeks.
5. *Pain over regional lymph nodes* which drain site of infection develops *forty-eight hours after symptoms begin.*
6. *Papule at site of inoculation twenty-four hours later.* This breaks down in a few days, leaving punched-out ulcer.
7. *Leukocytes* 10-15,000.
8. *Convalescence* slow. Many at work in three months—some not before six to twelve months. Final recovery without sequelae.



Fig. 1.—Ulceroglandular type of tularemia. Crater-like ulcer and enlarged epitrochlear lymph-nodes.

The clinical course is quite characteristic. The important points are brought out in Chart 4.

The incubation period is usually about three days, but may be as long as seventeen days. An analysis of the reported California cases in this regard is of interest. (Chart 5.)

BACTERIOLOGY AND IMMUNOLOGY

The causative organism of tularemia is Bacterium tularense. It is Gram-negative, non-motile and can be grown on dextrose egg-yolk or serum dextrose cystine agar. The organism can be isolated by injecting infected material subcutaneously into a guinea-pig or rabbit. In severe human cases the blood is found to cause the disease when injected into laboratory animals. Tularemia causes the formation of specific agglutinins in the blood. Chart 6 emphasizes the important facts in regard to agglutination in this disease.

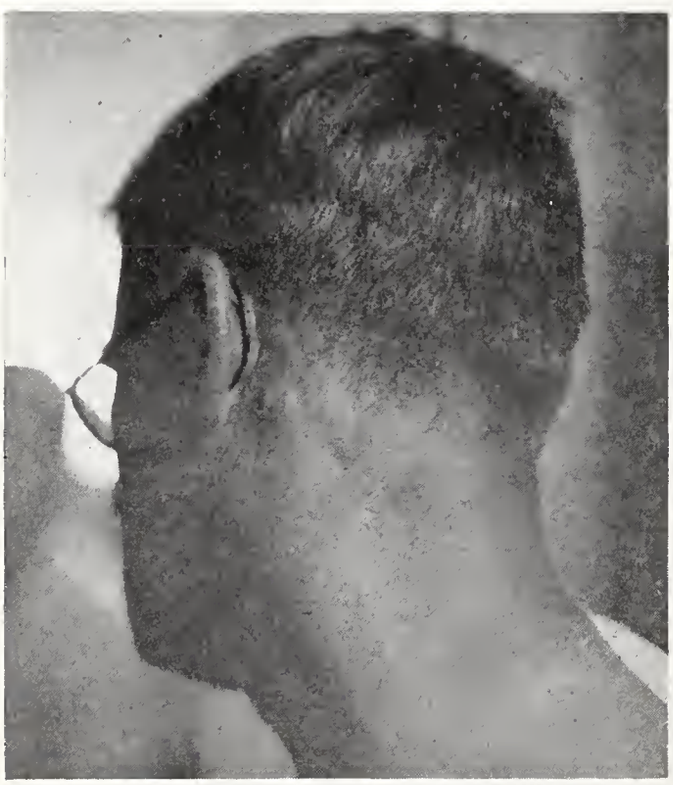


Fig. 2.—Ulceroglandular type of tularemia. Scar from ulcer and enlarged regional lymph-nodes.

Prophylactic vaccination has been carried out by Foshay.[7] It is satisfactory to protect man against laboratory infections, but it is not practical for the rabbit hunter.

PATHOLOGY

Microscopic sections of the primary ulcer and region lymph nodes in man show a chronic inflammatory reaction not unlike that seen in tuberculosis. There are areas of focal necrosis, with an infiltration of endothelial cells and lymphocytes and an occasional giant cell.

In man and animals, the liver and spleen are studded with small white nodules that, on microscopic examination, are areas of focal necrosis. (Fig. 3.)

DIAGNOSIS

The clinical picture of the ulceroglandular and oculoglandular types of tularemia are so characteristic that it is difficult to confuse them with anything else. A history of exposure to wild rabbits, deer flies or ticks helps to confirm the diagnosis.

Early syphilis, a fulminating malignancy, an unusual pyogenic infection, sporotrichosis, and coccidioides must be considered in a differential diagnosis.

The typhoidal type of the disease may be more difficult to diagnose. As the name signifies, it is often confused with typhoid and paratyphoid infections. It generally occurs in people working with Bacterium tularense in the laboratory.

Positive agglutination can be obtained by the end of the second week. Foshay[8] has perfected an intradermal reaction that permits a positive diagnosis during the first week of the disease. (Chart 7.)

TREATMENT

Treatment was entirely symptomatic before the introduction of a specific antiserum by Foshay in 1932.[9,10,11] Rest in bed and incision of involved lymph nodes, when there was definite softening,

CHART 5.—*Tularemia: California Cases. Number of Days from Date of Exposure to Beginning of Symptoms. Information Given in Thirty-six Cases Only*

Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Number of Cases	0	2	11	6	2	0	7	2	0	1	1	0	2	0	0	1	1	0



Fig. 3.—Lymphnode-Tularemia. Microphotograph showing giant cell and characteristic round cell infiltration.

was the only treatment of value. Intravenous mercurochrome and arsphenamin, and quinin therapy, did not prove to be of value. The use of convalescent serum was also disappointing. Specific antiserum therapy is explained in Chart 8.

CHART 6.—*Agglutination in Tularemia*

1. *Absent from blood during first week, positive during second week,* at its maximum in three to seven weeks, when a decline in titre begins.
2. First week negative.
 Second week 1:10 to 1:640.
 Third week 1:80 to 1:1280.
3. *Cross agglutination* of Brucella melitensis and Brucella abortus in about one-quarter of cases, but in much lower dilution.
4. *Agglutinin absorption.* Tularemia serum after agglutination with tularense will no longer agglutinate tularense, melitensis or abortus. Tularemia serum, after agglutination with melitensis or abortus, will still agglutinate tularense as strong as previously.

PROGNOSIS

The death rate in tularemia is about 4 per cent. The disease is of long duration, and convalesence extends over a period of many months. The oculoglandular and typhoidal types of the disease are more serious than the ulceroglandular type. Death may result from the disease itself, but generally is due to some complication as pneumonia, heart disease, exploratory laporatomy, etc.

CHART 7.—*Tularemia: Intradermal Reaction (Foshay)*

1. One one-hundredth cubic centimeter intradermally of a heat-killed detoxified tularemic antigen.
2. Circular red area 5-6 centimeters in diameter in forty-eight hours.
3. Remains for five days—pigmented area for many weeks.
4. It is a specific reaction that begins on third or fourth day—one week before agglutins appear in blood—and remains for twelve to fifteen months.
5. Reactions become negative after serum treatment.

CHART 8.—*Tularemia: Specific Antiserum (Foshay)*

1. Specific antiserum prepared from vaccinated goats.
2. Should be given early to prevent glandular involvement. If liver and spleen are involved it is too late.
3. Two intravenous injections of 15 cubic centimeters are given on successive days. In typhoidal type—larger amounts of serum necessary.
4. Relief of symptoms, fall in temperature, decrease in size of lymph nodes within twenty-four hours after serum is given.
5. Antiserum is neither bacteriostatic nor bacteriocidal. Its action is due to its specific desensitizing action.
6. Antiserum therapy cuts disability from several months to a few weeks.

COMMENT

1. Eighty-eight cases of tularemia have been reported in California since 1927.

2. Tularemia is more common in Kern County than in other counties of the state. It is much more prevalent in Northern than in Southern California.

3. The intradermal reaction with killed detoxified antigen will give a positive diagnosis about one week before agglutinins appear in the blood.

4. Specific tularemia antiserum, if given early, will greatly shorten the course of the disease.

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DISCUSSION

JOHN F. KESSEL, Ph.D. (University of Southern California School of Medicine, Los Angeles).—Since tularemia received its name from Tulare County, where the etiologic agent, pasteurella tularensis, was first isolated in 1911, an opinion obtains in the minds of many that this disease is more prevalent in California than in other parts of the United States. In fact, it is no uncommon occurrence to meet those who have

heard the term "California disease," which is commonly used for coccidioidal granuloma, and who really think that the same applies to tularemia instead.

This timely analysis by Doctor Miller of California cases of tularemia recorded since this disease has become one reportable to the State Health Department should be of great value to us locally, as well as of interest to those out of the State. Several salient points are brought out in Doctor Miller's paper which bear comparison with more general findings concerning tularemia.

1. During approximately the same period, 1928 to 1933 inclusive, there have appeared in the United States Public Health Reports as occurring in the United States 3,496 cases, 151 being reported in 1928 and 763 in 1933. This marked increase is undoubtedly due to improved diagnosis and more general recognition of the cases from a clinical point of view. It is surprising that no cases were recorded in California between the years 1911 and 1927, at which time Doctor Miller made the first case report from this State. California, with her eighty-eight cases during this period, does not attain the State average of the other States in which the disease has been found—a fact somewhat surprising in view of its early announcement from this State. Several of the eastern central States, notably Ohio and Illinois, southern States including Virginia, and southwestern States, for example, Arizona, have an incidence much higher than the State of California.

2. Tularemia was first recorded from ground squirrels. Transmission from squirrels to man, however, is rare.

3. Recently, great emphasis has been placed on the possible rôle of gallinaceous birds, for example, quail, partridge, grouse, as important reservoir hosts for tularemia; and since arthropods, notably ticks, which infest these birds, have been found to carry the microorganism, these game birds, together with the ticks, have been considered sources of infection to man. Philip, Davis and Parker (1932) report the experimental transmission of tularemia by mosquitoes. The California series show rabbit contact to be the most common source of infection in this State, only nine cases of insect transmission and one case derived from a bird being mentioned. This last is listed as contact with a chicken bone. No statement is made as to whether the bone was from an uncooked or a cooked fowl, but one may suspect that the infection was acquired from the marrow, since Lille and Francis (1933) have recently shown bone marrow to be infected. There is at least one case in the literature in which infection was acquired through eating improperly cooked rabbit meat. Recent reports of Green and Shillinger indicate that strains of P. tularensis acquired from birds exhibit a much lower virulence than strains acquired from rabbits. Parker has recently shown that tularemia may be transmitted to sheep, and calls attention to the fact that mutton may act as a source of infection to man. These points all emphasize the necessity of having meats well cooked.

4. Another fact of interest is that only 15 per cent of the cases occurred in Southern California, while more than 50 per cent of the population of the State lives in Southern California. Whether this is due actually to a lower incidence of the disease or to its less adequate recognition in Southern California, remains to be seen.

Doctor Miller has given the latest information on diagnosis, prophylaxis, and treatment of tularemia, much of which is the work of one man, Doctor Foshay of Cincinnati. Clinical and laboratory men at large are waiting for corroboratory evidence, which will be greatly stimulated by the present report.

H. A. Wyckoff, M. D. (Lane Hospital, San Francisco).—Although Martin, as early as 1907, described cases in Arizona which, viewed in retrospect, appear to have been tularemia, and while it now seems probable that the disease existed in man unrecognized for a considerable period of time before this date, it was not clinically differentiated until 1911.

Since the latter date the number of cases of tularemia reported in the United States has tended to increase from year to year. This increase seems more dependent upon a growing familiarity with the disease than upon an increase in the disease itself. Still the number of cases which actually exist is probably much larger than the number recognized and reported.

Such articles as this by Doctor Miller are most useful in spreading information regarding the disease and in awakening medical men to the realization that it is not a medical curiosity, but what may be encountered in everyday practice.

The concise, yet comprehensive information presented in the charts is especially valuable.



Clair L. Stealy, M. D. (2001 Fourth Avenue, San Diego).—Cases of tularemia are not common in California, in comparison with other disease conditions, as Doctor Miller has shown in the chart accompanying his paper. Since 1927 but eighty-eight cases have been reported. However, tularemia presents a diagnostic problem of sufficient importance to make this paper very timely and of value to the medical profession in pointing out the symptomatology and pathology of the disease.

In June, 1928, California and Western Medicine published a paper by Dr. David Miller and myself, reporting the first two cases of tularemia from San Diego County. I recall very distinctly the puzzling symptomatology presented by these cases which led us to believe that we were dealing with a condition not common in California. Both patients looked desperately ill, but their general appearance was out of all proportion to their physical findings. One patient was seen ten days after having scratched his thumb while dressing rabbits. He had noted a small granulomatous area with some lymphangitis and swelling of the axillary glands. There was a low-grade temperature and a feeling of intense prostration and weakness. It seemed almost impossible that such a minor lesion could be responsible for such grave symptoms. The other case, which presented equally alarming symptoms, was that of a young man who had developed an eye lesion following the handling of some rabbits.

Our experience with these two patients showed us that the physical findings in a case of tularemia are not at all commensurate with the apparent severity of the disease. I therefore think that it behooves every physician attending a case of extreme prostration and weakness in which the physical findings are not sufficient to explain the alarming nature of the symptoms, and in which a history of animal contact is given. at least to rule out the possibility of tularemia.

If education does not afford opportunity for wholesome recreation and train capacity for seeking and finding it, the suppressed instincts find all sorts of illicit outlets, . . . Education has no more serious responsibility than making adequate provision for enjoyment of recreative leisure; not only for the sake of immediate health, but still more if possible for the sake of its lasting effect upon habits of mind.—John Dewey.

A MEDICAL-ECONOMIC SURVEY OF SACRAMENTO COUNTY*

By NATHAN HALE, M.D.
Sacramento

THIS survey of medical economics is submitted to the Chamber of Commerce for its approval, through myself as chairman of the Public Relations Committee.

In the Public Health Section of the Chamber of Commerce, the question naturally arises as to whether Sacramento County is doing her share in meeting the present emergency, particularly as to the percentage of financial distress in Sacramento County as compared with distress evidenced in other like counties, as indicated by expenditures of the State Emergency Relief Administration. If the Relief is expending more in Sacramento County than in other counties of its size in the State of California, one would expect a resultant strain upon the County Hospital, and the matter is of pertinent interest.

MEDICAL-ECONOMIC DEDUCTIONS FROM THE SACRAMENTO COUNTY STUDY

Accordingly, a careful and intensive study has been made of medical-economic factors in the County of Sacramento and State of California, as a result of which the following deductions are made:

1. Northern California and Sacramento County have less pro-rata "temporary poverty" than other portions of the State, particularly the southern portion. In general, areas of stabilized population have less "temporary poverty" than industrial areas, and particularly those areas where there is a combination of industry and tourist appeal.

2. Health factors of Sacramento Valley are being cared for under the present régime without added distress to the sick during this period of depression.

3. State provision for medical care and hospitalization would increase to a tremendous proportion the amount necessarily paid by the taxpayer. This statement is proven by a study of the relative occupancy of public and private hospitals; the numbers of patients treated and the lengths of hospitalization being determining factors, as hereinafter detailed.

4. Local health situations can be more efficiently met by county units through coöperative medical societies than by a state organization with a political background.

5. Individual preparedness and responsibility in meeting emergency, illness and distress need to be fostered through education.

6. It is the duty of all local Chambers of Commerce to plan in times of prosperity for incoming population so that uncontrollable catastrophies may not occur in the community during periods of depression.

* A report submitted to the Sacramento Chamber of Commerce, Sacramento, and accepted and unanimously approved by the Directors.
Read in part at the March 2 meeting of the House of Delegates of the California Medical Association.

In substantiation of these deductions, statistics are submitted which are accurate, having been obtained in large measure through the aid of the Department of Public Health of the State of California, and at no cost to the State, and particularly through the efforts of Guy P. Jones, State Registrar of Vital Statistics.

RELIEF WORK IN STATE OF CALIFORNIA

In October, 1934, there were 623,663 resident persons in the State of California on relief, which constituted 11 per cent of the total population of the State. These figures do not segregate the aged, blind and county farm type of indigent from those on relief due to the present emergency, and indicate that there are 109 individuals on relief per 1,000 of population.

RELIEF WORK IN SACRAMENTO AND COMPARABLE COUNTIES

The counties with populations between 100,000 and 150,000, according to the 1930 census, have the following percentages of relief:

TABLE 1.—*Showing Percentage of Population Receiving Relief in Agricultural Counties*

County	Population	Percentage of Relief
Sacramento	141,999	5.5
Fresno	144,379	5.3
Santa Clara	144,118	5.
San Joaquin	102,940	3.5
Orange	118,674	7.8
San Bernardino	133,900	21.7

This group of statistics tends to show that the agricultural and other stabilized areas outside the industrial areas, with the exception of San Bernardino County, have a lower percentage of population on relief than the industrial districts, which are represented by the following counties:

TABLE 2.—*Showing Percentage of Relief in Three Metropolitan Counties*

County	Population	Percentage of Relief
Alameda	474,883	7.6
San Francisco	634,394	11.1
Los Angeles	2,208,494	15.9

In considering the State as a whole, it is an interesting commentary that the majority of the counties requiring the greatest amount of relief in proportion to population are located in Southern California:

TABLE 3.—*Showing Percentage of Relief in Six of the Seven Southern California Counties*

County	Population	Percentage of Relief
San Luis Obispo	29,613	12.2
San Diego	209,659	14.2
Los Angeles	2,208,492	15.9
Riverside	81,024	16.8
Imperial	60,903	17.1
San Bernardino	133,900	21.7

The exception to this rule is Trinity County with a population of 2,809 and 17.4 per cent on relief.

COMPARATIVE STUDY OF INCOME AREAS

For the purpose of presenting a bird's-eye view of the comparative situation throughout the State, it may be stated that California's income is obtained through the major interests of mining, lumber, agriculture and its by-product, wine production, industry and tourist development. A brief study of these major interests in relation to relief may prove of value:

THE MINING COUNTIES

It is interesting to note that in the mining districts, most of which are in the northern portion of the State, there are few, and sometimes no cases on relief:

TABLE 4.—*Percentages for Some of the Mining Counties*

County	Population	Percentage of Relief
Alpine	241	None
Amador	8,494	1.6 (before gold strike) 6 (after gold strike)
Eldorado	8,325	1.9
Inyo	6,355	None
Mono	1,360	None
Nevada	10,596	7 (in September) 2.3 (in October)
Placer	24,468	1.9
Plumas	7,913	4
Modoc	8,038	1
Sierra	2,422	None
Tuolumne	9,271	13.5

THE LUMBER COUNTIES

The timber counties, those where the chief resource is obtained from exportation of lumber in its crude form, show an increase over the mining counties, probably on account of the curtailment of building in the cities, as follows:

TABLE 5.—*Percentages for Some of the Lumber Counties*

County	Population	Percentage of Relief
Alpine	241	None
Humboldt	43,233	3.7
Lassen	12,589	5
Mendocino	23,505	None
Merced	36,748	1.5
Shasta	13,927	3.8
Siskiyou	25,480	2
Tehama	13,866	9.6
Trinity	2,809	6.6 (in September) 17.4 (in October)

THE AGRICULTURAL COUNTIES

A consideration of relief in the agricultural areas surrounding Sacramento County indicates that these areas have weathered the storm well:

TABLE 6.—*Percentages for Some of the Agricultural Counties*

County	Population	Percentage of Relief
Solano	40,834	2.5
Sutter	14,618	3.1
Colusa	10,258	1.1
Lake	7,166	None
Glenn	10,935	4.6
Stanislaus	56,641	.2
Yolo	23,644	None

WINE PRODUCING COUNTIES

A factor to be reckoned with, though a recently renewed activity, is that of wine production, and mention of the wine producing counties is, therefore, pertinent:

TABLE 7.—*Percentages for Some of the Wine-Producing Counties*

County	Population	Percentage of Relief
Sacramento	141,999	5.5
Fresno	144,397	5.3
Mendocino	23,505	None
Napa	22,897	No report
Solano	40,834	2.5
Sonoma	62,222	3.7

INDUSTRIAL AND TOURIST COUNTIES

In the Bay district, which has not had so great a tourist influx, the figures of Table 8 obtain:

TABLE 8.—*Percentages for San Francisco Bay Region*

County	Population	Percentage of Relief
Alameda	474,883	7.6
Contra Costa	78,608	4.6
San Francisco	634,394	11.1

In Southern California, where there is a great tourist influx, the figures of Table 9 are highly significant:

TABLE 9.—*Percentages for Southern California Region*

County	Population	Percentage of Relief
San Diego	209,659	14.2
Riverside	81,024	16.8
Los Angeles	2,208,492	15.9
San Bernardino	133,900	21.7

DEDUCTIONS AS TO RELIEF

It is concluded, from the figures presented above, that the mining, lumber and agricultural districts, particularly in Northern California, which have not depended upon tourist influx in recent years, but have been established by a slow process of settlement, have fared better during the period of depression than those districts with a great influx of population, and without a program of preparedness and consideration of the ability of the community to assimilate increased population in a logical order. One can only conclude, though least is heard about it in legislative proposals, that the industrial or manufacturing centers urgently require a more intensive consideration of their problems.

RELIEF THROUGH HOSPITALIZATION

This study was undertaken, on behalf of the Public Relations Committee, with a particular view to the medical aspect of relief in the State. It seemed essential to establish a background and orientation of the necessity for relief before the medical response to that necessity could be dem-

TABLE 10.—*Maternity Statistics for Four California Counties*

County	Population	Mothers Admitted	Operations	Babies Born	Maternal Deaths	Infant Deaths	Stillbirths
Fresno	144,379	639	34	566	5	13	22
Orange	118,674	231	9	221	0	13	11
San Joaquin	102,940	634	34	639	3	10	11
San Bernardino	133,900	430	7	428	3	18	18

onstrated. With the background established, a concentrated study has been made of hospitalization, with a view to differentiation between private and charity hospitalization.

In 1933, the bed capacity of private hospitals in California was 17,536 and occupancy averaged 50 per cent, while beds in charity hospitals numbered 15,482, with an 80 per cent occupancy.

During 1933, the private hospitals of the State admitted 246,434 patients, not including 263,325 so-called "out patients"—that is, patients admitted for treatment but not remaining longer than one day. During the same period the charity hospitals admitted only 136,199 patients, including tubercular patients, with 206,499 "out patients." Therefore, with the private hospitals having 2,094 more beds than the charity hospitals, and private hospital beds 50 per cent occupied as compared with 80 per cent occupancy in charity hospitals, it is evident that a much greater length of time was required or consumed for convalescence in charity hospitals than in private institutions, with a greater consequent expense to the taxpayer and no revenue to the county or State, since all private hospitals pay city, county and State taxes.

It must not be forgotten that there are patients in county hospitals who have chronic diseases, which would accordingly increase the average of convalescent days. As a concrete example, 4,536 beds in county hospitals are allocated to tubercular patients, and approximately 3,764 such patients were admitted to these institutions in 1933. Nevertheless, the contrast is startling, since the figures above accurately quoted prove an average hospital stay of *12.9* days in private hospitals as against an average stay of *33.2* days in charity hospitals!

HOSPITALIZATION OF MATERNITY PATIENTS

Since it is impractical to quote a labyrinth of statistics, and since maternity cases are universally cared for in all districts, and to a certain extent may be studied as a criterion of the economic situation, a comparative résumé of this phase of hospitalization only has been attempted.

Sacramento County confined 744 mothers, upon whom it was necessary to perform ten operations. Some 744 babies were born, with one maternal death, nine infant deaths and nineteen stillbirths.

A comparison with counties of approximately the same population is given in Table 10.

It is particularly interesting to observe that Sacramento County, with a population of 141,999 and a percentage of 5.5 on relief, cared for *744* maternity cases, in comparison with only *430* maternity cases in San Bernardino County where 21.7 per cent is required in a population of only 8,000 less than Sacramento County.

As a further comparison:

San Diego County, with a population of 209,659, or approximately *twice* the population of Sacramento County, admitted 696 mothers, delivered 701 babies, with two maternal deaths, eighteen infant deaths and thirty stillbirths.

Alameda County, with a population of 474,883, or approximately four times that of Sacramento County, cared for 1,053 mothers, delivered 991 babies, with no maternal deaths, nineteen infant deaths and forty-six stillbirths.

One must conclude from this study that, with our low percentage of relief, 5.5 per cent, there was a very high percentage of maternal cases in the county hospitals even with restriction of admissions by the Social Service Department, unless it can be proved that the birth rate among the poor of Sacramento County was far greater than that of any other comparable county in California.

In any summation of relief, and particularly of medical care during this period of economic stress, it must be remembered that the physicians serving in all county institutions, with the exception of the practitioner acting as superintendent and the physician in charge of the laboratories, donate their services. Therefore, one cannot but conclude that the private physician is donating his time, which is his only resource, in the care of the public during their great emergency, in a more generous way than any other single individual or group of individuals in the entire State of California.

DISCUSSION OF PROBLEM PRESENTED

Apparently the trend of events has produced two groups of individuals, with differing methods which they consider adequate and feasible for the solution of the present economic problem. One group advocates nationalization of all types of medical care. Nor is this tendency limited to medicine: there has been a tendency, since the advent of the chain store, to regiment industry, first adopted by groups of individuals and now propagated by the national Government in the establishment of codes regulating industry and aided by financial disbursements to the states, thus obligating the state governments to the national Government, and likewise obligating county governments to state governments through acceptance and employment of funds thus provided.

The other group feels that this unequal distribution of poverty and sickness can best be cared for by smaller units represented by counties. Americans, as a people, have been rooted and

grounded in the democratic principles promulgated by Thomas Jefferson, as evidenced by this extract from his Inaugural Address:

"Were not this great country already divided into states, that division must be made, that each might do for itself what concerns itself directly, and what it can so much better do than a distant authority. Every state again is divided into counties, each to take care of what lies within its local bounds; each county again into townships, to manage minuter details; and every township into farms, to be governed each by its individual proprietor. Were we directed from Washington when to sow, and when to reap, we should soon want bread."

The equal distribution of tax throughout all the counties of the state in proportion to population, in caring for distress, must necessarily prove an unfair burden to those counties of the state which have been provident in providing for their own distress.

The medical profession realizes that the care of the sick has been an increasing burden to the

ADDENDA*

TABLE 11.—*Percentage of Population Receiving Relief in California, by Counties (August, September, and October, 1934)*

County	Population 1930 Census	Net (a) Resident Persons on Relief			Per Cent of Population		
		August	September	October	August	September	October
Total State	5,677,251	594,350	580,886	623,663	10.5	10.2	11.0
Alameda	474,883	40,829	36,168	36,003	8.6	7.6	7.6
Alpine	241	(c)	(c)	(c)	(c)	(c)	(c)
Amador	8,494	103	135	506	1.2	1.6	6.0
Butte	34,093	1,216	1,716	2,311	3.6	5.0	6.8
Calaveras	6,008	(d)	(d)	(d)	(d)	(d)	(d)
Colusa	10,258	76	93	115	.7	.9	1.1
Contra Costa	78,608	4,296	6,090	3,614	5.5	7.7	4.6
Del Norte	4,739	260	283	190	5.5	6.0	4.0
El Dorado	8,325	75	113	159	.9	1.4	1.9
Fresno	144,379	7,785	7,623	7,595	5.4	5.3	5.3
Glenn	10,935	391	399	500	3.6	3.6	4.6
Humboldt	43,233	1,420	1,158	1,614	3.3	2.7	3.7
Imperial	60,903	8,023	9,040	10,443	13.2	14.8	17.1
Inyo	6,555	(c)	(c)	(c)	(c)	(c)	(c)
Kern	82,570	5,511	4,924	5,231	6.7	6.0	6.3
Kings	25,385	491	446	631	1.9	1.8	2.5
Lake	7,166	(c)	(c)	(c)	(c)	(c)	(c)
Lassen	12,589	299	407	630	2.4	3.2	5.0
Los Angeles	2,208,492	329,074	327,236	351,989	14.9	14.8	15.9
Madera	17,164	150	162	654	.9	.9	3.8
Marin	41,648	1,267	1,290	1,322	3.0	3.1	3.2
Mariposa	3,233	(d)	(d)	(d)	(d)	(d)	(d)
Mendocino	23,505	(c)	(c)	(c)	(c)	(c)	(c)
Merced	36,748	590	529	535	1.6	1.4	1.5
Modoc	8,038	9	16	83	.1	.2	1.0
Mono	1,360	(c)	(c)	(c)	(c)	(c)	(c)
Monterey	53,705	1,905	2,148	2,149	3.5	4.0	4.0
Napa	22,897	(d)	(d)	(d)	(d)	(d)	(d)
Nevada	10,596	7	69	241	.1	.7	2.3
Orange	118,674	7,685	7,937	9,211	6.5	6.7	7.8
Placer	24,468	7	265	476	(b)	1.1	1.9
Plumas	7,913	(d)	(d)	29	(d)	(d)	.4
Riverside	81,024	14,153	13,143	13,575	17.5	16.2	16.8
Sacramento	141,999	5,184	6,350	7,836	3.7	4.5	5.5
San Benito	11,311	68	77	103	.6	.7	.9
San Bernardino	133,900	25,066	26,144	29,097	18.7	19.5	21.7
San Diego	209,659	25,692	25,511	29,701	12.3	12.2	14.2
San Francisco	634,394	79,937	69,777	70,111	12.6	11.0	11.1
San Joaquin	102,940	2,711	3,488	3,612	2.6	3.4	3.5
San Luis Obispo	29,613	3,523	3,569	3,598	11.9	12.1	12.2
San Mateo	77,405	5,280	4,967	5,093	6.8	6.4	6.6
Santa Barbara	65,167	3,721	4,758	4,756	5.7	7.3	7.3
Santa Clara	145,118	7,379	4,828	7,301	5.1	3.3	5.0
Santa Cruz	37,433	792	854	1,579	2.1	2.3	4.2
Shasta	13,927	573	512	528	4.1	3.7	3.8
Sierra	2,422	(c)	(c)	(c)	(c)	(c)	(c)
Siskiyou	25,480	472	492	500	1.9	1.9	2.0
Solano	40,834	533	667	1,030	1.3	1.6	2.5
Sonoma	62,222	1,517	1,940	2,283	2.4	3.1	3.7
Stanislaus	56,641	206	245	107	.4	.4	.2
Sutter	14,618	239	250	451	1.6	1.7	3.1
Tehama	13,866	625	463	1,335	4.5	3.3	9.6
Trinity	2,809	172	186	488	6.1	6.6	17.4
Tulare	77,442	1,080	565	424	1.4	.7	.5
Tuolumne	9,271	1,222	1,156	1,248	13.2	12.5	13.5
Ventura	54,976	2,442	1,989	1,989	4.4	3.6	3.6
Yolo	23,644	(d)	(d)	(d)	(d)	(d)	(d)
Yuba	11,331	294	708	687	2.6	6.2	6.1

(a) Duplications excluded.
(b) Less than one-tenth of one per cent.
(c) No cases.
(d) No report.

* Addenda include additional tables to the paper by Doctor Hale.

TABLE 12.—*Births in County Hospitals for Year 1933*

County	Mothers Confined	Cesarian Operations	Other Operations Performed	Babies Born	Maternal Deaths	Deaths Infant	Stillbirths
Alameda	1,053	17	90	991	0	19	46
Amador							
Alpine							
Butte	77			77			3
Calaveras	9			9			1
Colusa	23			19			4
Contra Costa	118	3	8	117	2	2	1
Del Norte	13			12			1
El Dorado	6		1	6			
Fresno	639	12	32	566	5	13	22
Glenn	2			3		1	
Humboldt	152	10	44	154		1	3
Imperial	115	11	12	115		2	4
Inyo							
Kern	476	15	1	447		12	17
Kings	87	1	3	87	1		2
Lake	4			4			
Lassen							
Los Angeles	3,397	99	161	3,434	25	255	144
Madera	91	6	2	94	3	3	1
Marin							
Mariposa							
Mendocino	17			17			
Merced	207	3		210		4	3
Modoc	4			4			
Mono							
Monterey	103	5	25	122	2	4	8
Napa	3			3			
Nevada							
Orange	231	9		221		13	11
Placer	40	4	1	36		1	3
Plumas	4			4			
Riverside	197	3	5	197	1	2	12
Sacramento	744	3	7	744	1	9	19
San Benito	1				1		1
San Bernardino	430	7		428	3	18	17
San Diego	696	3	152	701	2	18	30
San Francisco	784	15	167	795	2	35	37
San Joaquin	634	12	22	639	3	10	11
San Luis Obispo	120	4		112	1	1	8
San Mateo	148	2	28	148		2	9
Santa Barbara	126	7		127		3	4
Santa Clara	606	5	150	611		14	21
Santa Cruz	93	5		95		3	1
Shasta	47		1	57	1	1	4
Sierra							
Siskiyou	103	2		96	1	2	5
Solano	71	2		72		1	1
Sonoma	148	2	18	153	1	7	5
Stanislaus	196	33	27	199	3	9	5
Sutter	97			100		4	1
Tehama	40			40		3	
Trinity							
Tulare	259	7	6	261		8	5
Tuolumne	26	4	2	26		1	
Ventura	198	3	18	201	1	17	3
Yolo	53			54			2
Yuba	36	1	1	36		6	
Totals	12,885	321	989	12,767	59	510	478

TABLE 13.—*Hospital Statistics for Private Hospitals in California for Year 1933*

Name	Bed Capacity	Average Number of Patients	Patients Admitted 1933	Out-Patients
Children's	328	235	5,929	15,794
Chronic	25	8	195	135
Eye and Ear	50	14	3,589	10,533
Church	4,804	2,317	76,514	90,819
Fraternal	531	335	6,760	8,477
Independent	6,034	2,828	105,978	94,262
Individual	1,637	604	23,445	16,144
Industrial	731	466	8,658	16,654
Partnership	264	132	3,717	417
Metabolic	28	14	5,160	
Nervous and Mental	1,222	830	1,561	
Orthopedic	145	133	1,905	6,715
Tuberculosis	1,356	940	1,592	1,993
Maternity	381	234	1,431	1,382
	17,536	9,090	246,434	263,325

TABLE 14.—*Statistics for County Hospitals in California for Year 1933*

Name	Bed Capacity	Average Number of Patients	Patients Admitted 1933	Out-Patients
General	10,946	9,114	136,199	206,499
Tuberculosis	4,536	3,764	2,700	6,000
	15,482	12,878	138,899	212,499

TABLE 15.—*Statistics for State Hospitals in California for Year 1933*

Name	Bed Capacity	Average Number of Patients	Patients Admitted 1933	Out-Patients
Drug and Mentally Defective	812	652		
General	3,353	3,013	11,938	10,742
Mental	19,840	18,879	7,328	1,207
	24,005	22,544	19,266	11,949

TABLE 16.—*Statistics for Federal Government Hospitals in California for Year 1933*

Name	Bed Capacity	Average Number of Patients	Patients Admitted 1933	Out-Patients
Army General	865	695	7,427	16,508
General	13	6	293	
Indian Affairs	126	68	1,918	18,108
Veterans' Tuberculosis and General	1,550	1,240	4,984	
U. S. P. H. S.	2,435	1,606	17,224	30,327
	4,989	3,615	31,846	64,943

TABLE 17.—*Summary for Private, County, State and Federal Hospitals in California*

Name	Bed Capacity	Average Number of Patients	Patients Admitted 1933	Out-Patients
Private	17,536	9,090	246,434	263,325
County	15,482	12,878	138,899	212,499
State	24,005	22,544	19,266	11,949
Federal	4,989	3,615	31,846	64,943
	62,012	48,127	436,445	552,716

TABLE 18.—*Compilation of 1933 Maternity Home and Hospital Reports*

Total number live births in California—1933.....75,229

Reports of	No. Mothers Confined	No. Cesareans	No. Other Operations	No. Babies Born	No. Maternal Deaths	No. Infant Deaths	No. Stillbirths
50 county hospitals	12,885	321	989	12,767	59	510	478
408 licensed maternity homes and hospitals	37,020	1,847	3,854	37,050	87	758	846
Totals	49,905	2,168	4,843	49,817	146	1,268	1,324
480 institutions (50 county hospitals) (430 licensed institutions*)	49,771	2,186	5,838	50,280	178	1,338	1,341

California—Total live births, 1933.....75,229
Total infant deaths, 1933..... 4,022—53.4
Total stillbirths, 1933..... 2.032
Total maternal deaths, 1933..... 364— 4.8

* Seven licensed institutions unreported.

government, as represented by government-controlled institutions; that the evolution of this care should be carefully considered before any radical steps are taken; and that all medical care should be as free of embarrassing political alliances as it is possible to make it. This point should be emphatically stressed, as it is well known that disturbance is invariably caused through the injection of politics; that the physically-sick often are not capable of sound judgment during emergency; and that the profession, realizing this, should be of the highest standard in ability to care for the sick and of the highest standard morally to properly direct incapacitated sufferers.

This survey tends to prove that Sacramento County, although caring for a larger quota than other comparable counties, has taken care of the needy sick without undue financial distress to the county except to the physicians themselves; and that the county hospital should be carefully supervised in its Social Service Department, so that an unnecessary burden of taxation need not be placed upon the people of the county.

It would further seem that the sudden financial burden of unexpected illness requiring hospitalization can be solved by a type of insurance under proper medical and other supervision, originating in the county. This plan provides safe and adequate private hospitalization for the individual, through voluntary payment of a small sum monthly while in good health. Those improvident individuals who fail to set aside a small sum at stated intervals to provide for possible illnesses constitute the group who are improvident in other

economic arrangements for their future, and it is this group which brings the greatest amount of burden to the taxpayer during periods of depression.

IN CONCLUSION

Two methods evolve for the solution of these problems: (1) Compulsory taxation; (2) Education through publicity; and I quote the words of a distinguished Californian:

"We are challenged with a peace-time choice between the American system of rugged individualism and a European philosophy of diametrically opposed doctrines—doctrines of paternalism and state socialism. The acceptance of these ideas would mean the destruction of self-government through centralization of government and the undermining of the individual initiative and enterprise through which our people have grown to unparalleled greatness."

DIETARY MANAGEMENT IN PREGNANCY*

By Donald G. Tollefson, M.D.
and
Katharine Brown, B.S.
Los Angeles

Discussion *by Robert H. Fagan, M.D., Los Angeles; L. Grant Baldwin, M.D., Pasadena; Edward N. Ewer, M.D., Oakland.*

IN presenting this subject of Dietary Management in Pregnancy we have attempted to eliminate, in so far as possible, reference to the more complex factors concerning dietetics in general. The purpose of this essay is to call your attention to the necessity of diet. and its advantages to both the mother and the unborn infant.

CONNOTATION OF THE WORD DIET

The word diet should not necessarily imply the limitation of food intake, but rather the intelligent selection of the articles of food that go to make up daily nourishment. There is need for such advice. Because a prospective mother appears healthy, it does not mean that she is eating the proper foods. The newspapers, lay magazines and radio speeches are replete with misinformation. The public has been impressed with the importance of diet and is anxious to eat correctly. The physician must be capable of directing this enthusiasm into the proper channels.

DIETARY SUPERVISION OF IMPORTANCE IN PREGNANCY

In pregnancy, with the health of both the mother and infant to be considered, dietary supervision assumes major importance. Bingham [1] concludes that diet helps to prevent toxemia and reduces anemia. It makes labors easier because of the reduction of fat in the pelvis, and secondly because the babies are usually smaller. Mellanby,[2] Green and others have stressed the importance of vitamin A in preventing puerperal sepsis. Mathieu [3] in *Northwestern Medicine* stressed its need for dental protection. E. Vogt [4] states that a lack of vitamins may be a causative factor in habitual abortion and intrauterine death of the fetus. Reed,[5] in an excellent contribution, "The Calcium Problem in Pregnancy," emphasizes the rôle of this mineral in preventing decalcification of the teeth and as a protector of liver metabolism. Several references to his article will be made. While many authors have dealt with the effect of limitation of weight gain on the size of the fetus, from our observation it appears that oversized babies may be largely prevented. We have observed that the weight of infants under seven to seven and one-half pounds does bear some relation to the maternal gain.

For purely cosmetic reasons (the prevention of obesity) and the minor discomforts, as well as some of the constitutional disturbances of pregnancy, we believe diet is of paramount importance in prenatal care.

Adair,[6] in his chairman's address before the American Medical Association, points out that the needs of the fetus during intra-uterine life are not unlike those of early infancy. The fetus being a parasite, obtains its minerals and vitamins at the expense of the mother. It would seem apparent that if adequate allowance is made for these essentials in the maternal diet, there would be little possibility of depleting the mother's supply and the fetus will be better able to withstand the hazards of extra-uterine life.

DIETARY ESSENTIALS FOR THE PREGNANT WOMAN

What, then, are the essentials of the dietary requirements of the pregnant woman?

1. Protein must be in adequate amount to provide for maternal tissue repair as well as growth of the fetus. In pregnancy there is an alteration in the nitrogen equilibrium. Serious damage will occur if this level is not maintained. It is necessary, therefore, for a daily intake of at least one gram of protein per kilogram of body weight.

2. Carbohydrates are essential for energy, and must meet the demands of the growing fetus as well as the higher metabolic rate in pregnancy.

3. Fat is a concentrated source of energy and a good source of vitamin A; but most pregnant women would gain too much if the fat intake was not controlled.

4. Water requirements are met by the demands of a proper mineral balance in the blood. Excessive increase in weight is a danger signal in toxemias. The normal intake of fluids should be 2000 to 3000 cubic centimeters.[7]

5. Iodin is obtained from eating sea-food at least once a week, and is of particular importance in certain sections of the country to prevent goiter.

6. Most essential of the minerals are calcium, phosphorus and iron. Need of calcium is best expressed by a quotation from Richardson's article,[8] "The Rôle of Viosterol in Pregnancy": "There is no body tissue that is not influenced by or has an influence upon calcium metabolism, either in composition, building, maintenance or function of that

* From the Department of Obstetrics and Gynecology, University of Southern California School of Medicine.

Read before the Los Angeles Obstetrical Society, April 10, 1934.

tissue. Calcium is part and parcel of blood, muscle and bone; it is essential to growth, normal action of the heart, skeletal muscle and the coagulation of blood." As early in pregnancy as the seventeenth week calcium is deposited in the teeth and bones of the infant. The demands gradually increase throughout pregnancy, and during the latter months the calcium phosphorus level in maternal blood will be deficient unless it is supplied by diet or some easily assimilated product.

In order that calcium and phosphorus may be utilized and absorbed, vitamin D must be present; because even in the presence of a high calcium and adequate phosphorus intake, metabolism of these minerals will not be sufficient in the absence of vitamin D. Vitamin A must be present for growth and also has an anti-infective property.

Vitamin C must be present in adequate amounts to prevent the nutritional deficiency disease of scurvy. The importance of this vitamin in the pulp of teeth has been emphasized by Hanke.[9] The antineuritic factor of vitamin B has a definite effect on the function of the alimentary tract. With adequate supply, foods are more completely digested and absorbed, and the neuromuscular control of the intestine tends to be more normal. Vitamin B is in greater demand during reproduction and lactation than for growth and maintenance of health alone.

CHIEF SOURCES OF THE ESSENTIAL MINERALS

Chief sources of the essential minerals are outlined in this summary:

Calcium—
- Milk or buttermilk
- Milk products
- Commercial products

Iron—
- Rare beef and liver
- Egg-yolk
- Oysters
- Some from fruits as peaches, apricots, prunes. Some from leafy vegetables.

Phosphorus—
- Milk or milk products
- Eggs
- Meat, fish, poultry
- Commercial products

Iodin—
- Sea foods

Many other foods contain these minerals, but the above foods offer the richest sources.

The sources of vitamins and their functions are shown in this table:

RICH SOURCES AND FUNCTIONS OF VITAMINS

VITAMIN A—

Sources:
- Haliver or cod liver oil
- Butter
- Milk and cream
- Egg-yolk

Functions:
- Promotes growth
- Protects against infection
- Prevents xerophthalmia

VITAMIN B—

Sources:
- Commercial products B-Ton, wheat germ, Brewer's Yeast
- Whole grain cereal products

Functions:
- Aids action of digestion
- Promotes health
- Stimulates lactation
- Stimulates appetite
- Prevents beriberi

VITAMIN C—

Sources:
- Raw fruits and vegetables, especially orange, tomato, lemon and pineapple

Functions:
- Promotes good tooth and bone development
- Prevents scurvy

VITAMIN D—

Sources:
- Haliver oil with viosterol, cod liver oil, tuna liver oil and viosterol
- Perhaps small amount in milk and egg-yolks

Functions:
- Prevents rickets, acts as mobilizer for calcium and phosphorus

BARBORKA'S SCHEDULE FOR NORMAL NUTRITION

For practical purposes we use as a normal standard for pregnancy certain requirements based on Barborka's[10] schedule for normal nutrition; the only difference being the increase of milk to one quart. The items of this diet are listed as follows:

Milk or buttermilk	1 quart
Egg (yolk especially)	1
Meat, fish or poultry, especially rare beef and liver; fish once a week	1 serving
Fruits	2 servings (one to be raw)
Vegetables	3 servings (one raw, one leafy)
Butter	1 tablespoon
Whole-grain cereals or whole-grain bread	2 servings

This food list answers all requirements for the essentials just discussed. While additional foods must be added for the caloric requirements (30 to 33 calories per kilogram of normal weight), an individual on such a regimen will not suffer from lack of minerals, vitamins or proteins. From this diet all others must be built, for the therapeutic value of restriction or limitation will be jeopardized if these elements are not included.

NAUSEA AND VOMITING

The first condition in pregnancy we are most often called on to treat is nausea and vomiting. Approximately 50 per cent of patients have this discomfort of pregnancy. A routine which has been followed with considerable success includes the following:

Six small meals each day.

The diet should contain at least 2,500 calories.

Eight glasses of water, in addition to that secured in food.

No fried or greasy foods permitted.

Food must be taken with clock-like regularity, and may be considered as medicine.

As often as possible the patient should take candy, such as fruit-balls, which are practically pure sugar.

This diet being high in carbohydrate (containing about 450 grams) and in excess of requirements as to calories, will allow for loss of food not retained. Having a definite routine beginning with two Uneeda biscuits before the patient arises in the morning, and three-hour feedings, there is an almost constant stream of energy-producing food entering the stomach. Even if food is retained for as short a time as fifteen minutes, there will be some absorption. This high carbohydrate diet prevents acidosis, and within a few days nearly all food will be retained.

A sample diet is as follows:

7:00 a. m.
- Before arising chew two Uneeda biscuits. Stay in bed at least fifteen minutes thereafter. Then get up slowly and dress slowly.

7:30 a. m.
- Stewed prunes, baked apple or orange (with a large amount of sugar)—one serving.
- Oatmeal, cream of wheat, shredded wheat, wheat or corn flakes (with milk and sugar)—three-quarters cup.
- Toast or zwieback—one or two slices.
- Honey, marmalade or jam—one tablespoon
- Cocoa or milk—one glass.

10:00 a. m.
- Toast—one slice—or crackers—three.
- Milk or malted milk—one glass.

12:30 p. m.
Milk soup (with potato, corn or peas)—one serving.
Boiled rice, boiled or baked potato—three tablespoons.
Toast or crackers.
Vegetable or salad, with very little dressing—one serving.
Pudding or ice cream—one serving.

3:30 p. m.
Toast, crackers or cake—one serving.
Cocoa or tea—one cup.

6:30 p. m.
Milk soup—one serving.
Chicken, fish or lamb—one medium serving—or
Eggs (never fried)—two.
Macaroni, rice or potato—three tablespoons.
Vegetables—one or two servings.
Toast, zwieback or crackers.
Pudding—one serving.

Bedtime:
Cake or dried fruits—one serving.
Candies or fruit drops between meals, as often as possible.

In nearly 500 pregnancies nausea and vomiting diets have been used in 153 instances; seven required subsequent hospitalization. Only one was aborted because of persistent jaundice after repeated treatment with intravenous glucose, hypodermoclysis and the usually accepted therapy.

GAIN IN WEIGHT IN PREGNANCY

The normal gain in pregnancy is variously estimated at from fifteen to thirty pounds. Some place no limit on gain in weight. Our plan has allowed fifteen to twenty pounds over the usual weight. For underweight patients twenty-five pounds may be gained, but a much lower increase is advisable for the obese. The weight taken at the first visit is not their usual weight, because it is well known that most patients lose during the first two to three months of pregnancy. But, based on their accustomed weight, we find that ninety-nine of 143 of these patients were underweight for their height and age, and four were normal. Forty were overweight. The average gain in weight was twenty and one-half pounds. There was one pregnancy under eight months. The mothers of six prematures gained an average of nineteen pounds. The average weight of 146 infants (three sets of twins) was six pounds fourteen ounces, while the average, if the prematures and twins are excluded, was seven pounds three-quarters ounce. In 150 patients not controlled by diet the average weight of the infants was seven pounds eight ounces.

OVERWEIGHT IN PREGNANCY

In thirty patients we limited the intake of food after nausea and vomiting ceased. They were put on diets of from 1175 to 1525 calories. The minimum requirements for essentials were still maintained. Viosterol in haliver oil and commercial products of calcium diphosphate are routinely given after the third month, so the milk can be skimmed and reduced to a pint, and calcium will still be adequate. Haliver oil will supply vitamin A, so the butter can be restricted. With these changes the diet can be reduced to 900 calories and still be protective as advised.

A sample diet follows:

Diet for Obesity in Pregnancy.—Daily requirements for an obese patient call for the normal patient's using skim milk in place of whole. Twenty to twenty-five calories per kilogram of normal weight should be allowed, depending on the degree of obesity.

Sample menu, for a woman, of sixty-seven kilograms, twenty-two calories per kilogram:

Breakfast—	
Fruit, unsweetened	1 large portion
or	
Fruit juice	6 ounces
Egg, poached or boiled	1
Toast	1 slice
Butter	½ tablespoon
Skimmed milk	8 ounces
Coffee, if desired	1 cup
Luncheon—	
Egg	1
or	
Dry cottage cheese	3 tablespoons
Vegetable salad, without dressing	1 large serving
Fruit	1 medium portion
Skimmed milk or buttermilk	8 ounces
Afternoon—	
Skimmed milk or buttermilk	8 ounces
Dinner—	
Clear broth	¾ cup
Lean meat, fish or poultry	1 average serving
Potato, peas, lima beans or corn	1 medium portion or 3 tablespoons
Vegetables	3 tablespoons
Butter	½ tablespoon
Salad (vegetable)	1 small serving
Fruit	1 medium portion
Skimmed milk	8 ounces

Approximately 1470 calories, 74 grains protein.

In these thirty patients, where the diet was restricted for purpose of reducing weight, the largest overweight was 122 pounds, a hypopituitary type under treatment prior to pregnancy. The average overweight was twenty pounds. The average gain in weight during pregnancy was fourteen pounds. The smallest gain was two and one-half pounds. Twelve patients gained less than ten pounds. Considering that obese patients are much more difficult to control, it seems that it was a distinct advantage to diet during pregnancy. Small doses of one to three grains thyroid were given daily where evidence of hypothyroidism existed, but no large amounts were used to control weight.

DIET IN TOXEMIA OF PREGNANCY

In the dietary management of patients showing toxic symptoms, three principles should be kept in mind: restriction of fluids, salt-free diets, and protein protection.

Fluids were restricted in twenty-one instances in our series. Either the patient began to show edema, had headaches, dizziness or spots before the eyes, the blood pressure was elevated or the urine showed more than a trace of albumen. Through the work of Arnold and Fay,[11] the value of keeping the intake below the output was clearly shown. The fluids are restricted to forty-four ounces, consisting of:

16 ounces of whole or skimmed milk
16 ounces of water
6 ounces of coffee or tea or additional water or fruit juice
6 ounces of fruit juice

No salt in cooking or on foods when served. Otherwise the normal standard is followed as previously outlined. In addition, magnesium sulphate may be given by mouth. Fourteen of the twenty-one patients were considered true toxemias of pregnancy. In one, a patient with acute nephritis following a severe tonsillitis, pregnancy was

terminated at the seventh month. All others went to term. In fact two patients did not show marked evidence of toxemia until the onset of labor. One was a premature separation of the placenta. The patient was delivered by section. Another had a blood-pressure of 166/104 on admission to the hospital. She was an elderly primigravida at term, and the pressure returned to normal on the third day postpartum.

The low protein diet was never ordered for our patients. The work of Trumper and Cantarow [12] and others has definitely shown that this restriction further reduces the nitrogen level, and a nutritional edema may follow due to utilization of body tissue for protein requirements. Calories need not be reduced unless obesity is present.

As stated elsewhere in this paper, in the latter months of pregnancy the blood calcium level decreases. Mitchell [5] has called attention to the value of calcium in eclampsia. According to Major [5] the presence of guanidine is responsible for the eclamptic convulsion. It is a waste product resulting from voluntary muscle action, and is neutralized normally by calcium. The prompt relief of symptoms may follow the intravenous use of ten cubic centimeters of 10 per cent calcium gluconate. If the addition of calcium has this effect, why shouldn't it be used throughout pregnancy to assure adequate supply?

The importance of intestinal elimination should also be stressed. When toxemias are considered, forty patients were on anticonstipation diets. The diet used for constipation is as follows:

In addition to the normal requirements stress:
At least eight servings of fruits or vegetables;
At least eight glasses of water;
Buttermilk in preference to sweet milk;
Avoid boiled milk and all finely milled cereal products.

DENTAL HYGIENE

Finally, the dental problem is one that should receive more attention than it has in the past. Evidence of dental caries is not uncommon in the middle trimester of pregnancy. Decay of unerupted teeth [5] is reported showing that focal infection is not the only source of tooth destruction. The fetal requirements will come from the food or the mother's own teeth and bones. In American diets calcium intakes are conspicuously low. These fetal demands must be met or the host will suffer. One gram daily is necessary to provide this balance. Routine administration of calcium in any of the standard commercial forms should be followed by all obstetricians. Vitamin D in the form of cod liver oil or haliver oil must be present in order that calcium may be utilized. Vitamin A is the anti-infective vitamin, and its addition will aid in the prevention of focal infection in teeth. These same factors with vitamin C are involved in the proper cellular nutrition of the pulp, peridental membrane and gingival tissue. Protection of the infant's teeth, as well as those of the mother, begins early in pregnancy.

USE OF COMMERCIAL PRODUCTS

The commercial products used and the dosage advised are:

COMMERCIAL PRODUCTS

	Dosage	Cost
Vitamin A—		
Haliver oil with viosterol	20 drops daily	$4.50— 55 c.c.
	or	
	2 capsules	$4.25—100
Vitamin B—		
B-Ton	2 tablespoons daily	
or		
Wheat germ	2 tablespoons daily	
or		
Brewer's yeast tablets	4 daily	
Vitamin D—		
Haliver oil with viosterol	20 drops or 2 capsules	
Calcium		
Dicalcium phosphate	3 segments daily	
or		
Mineral mixture	4 tablets daily	
Phosphorus—same as calcium.		

IN CONCLUSION

1. A normal standard diet of nutrition is essential to adequate prenatal care.

2. Nausea and vomiting can be controlled in most instances by high carbohydrate diet.

3. Obesity can be treated during pregnancy, provided the diet is protective for proteins, minerals and vitamins.

4. That gain in weight can be largely controlled and may prevent a certain percentage of overweight infants.

5. Calcium and phosphorus must be recognized not only for the fetal requirements, but as an established benefit in toxemias, and as an essential in dental prophylaxis.

6. That to be certain of mineral and vitamin consumption, they had best be added to the diet during the latter months of pregnancy in commercial form.

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DISCUSSION

ROBERT H. FAGAN, M. D. (1136 West Sixth Street, Los Angeles).—A few years ago I was solicited by a dietitian with the suggestion that my patients enroll in her proposed class to learn what to eat, and why, during pregnancy. I was somewhat disturbed by her suggestion, and retorted that my patients employed me for that purpose, among others, and what right had I to ask them to seek elsewhere the advice I was

obligated to give? However, her visit caused me to assay my knowledge of dietetics, and I became chagrined at my ignorance on the subject.

Today the easily given general advice to follow one's inclination or to eat a balanced diet, is as antiquated as the prenatal care which consisted in the patient first contacting her doctor when labor started. Patients are not only entitled to, but nowadays demand individualized or specific dietary advice.

Doctor Tollefson has outlined the basic requirements for the prospective mother and her offspring, and has indicated how the administration of these foodstuffs may ward off or relieve some of the unwelcome complications of pregnancy.

For the patient with nephritis, diabetes, anemia or heart trouble, our only hope for success lies chiefly in the proper dietary regimen. In addition, the majority of our patients' minor ills, and certainly the majority of their complaints are due to dietary errors.

Unfortunately, in the matter of diets we are all apt to become faddists, and the pendulum swings too far in the direction of commercial products reported to be indispensable to good health because of mineral or vitamin content. To mention one drug: the use of viosterol has been abused in this respect, and in some cases it has been even harmful in producing overcalcification of the tissues.

Likewise, often unnecessary or even harmful dietary restrictions are given, an example of which is the too rigid limitation of proteins during nephritis. Red meats are often inadvisedly restricted. In the first place, the term "red meats" is ambiguous; in the second place, according to Alvarez and contrary to the general belief, red meat is often more easily digestible than white meat, because it contains less connective tissue. It is likewise doubtful if it is appreciably more harmful to the excretory organs, and there seems no reason for restricting it unduly in the normal expectant mother, as is often so routinely done.

Heartburn, flatulence, constipation and discomfort from hemorrhoids, which present a large portion of the complaints of our patients, may all be alleviated by the correction of dietary indiscretions.

Heartburn is most often due to overeating, to not eating often enough, to eating when one is fatigued, or to eating too highly spiced or too fatty foodstuffs. Many patients, unwilling to make the necessary dietary corrections, find relief in the administration of soda mints or alkaline drinks, or powders which contain pepsin or peppermint. Flatulence is chiefly attributable to the fermentation of carbohydrates which have reached the colon without being digested. Here one will find it helpful to limit uncooked fruits and vegetables, for the process of cooking aids in their digestion in the small bowel and inhibits the too rapid emptying of the gastro-intestinal tract. Constipation, often of many years' duration, is a major dietary problem. Here the water intake, and the regularity of quantity and quality of waste introduced into the system daily, are the important factors to be controlled. In my experience, too much roughage may be harmful in addition to predisposing to hemorrhoids. A smooth soft residue is desirable. Adequate rest is also important in the prevention of hemorrhoids. Mineral oil may frequently be helpful; however, it should not be taken with meals, as it coats the foodstuffs and makes them less readily accessible to the digestive enzymes.

Owing to the relatively long period that patients are under our supervision, we often have the opportunity of correcting many of their lifelong, erroneous habits; and thus we are privileged, in many instances, to serve not only as accoucheurs, but as physicians whose advice improves their habits in the general hygiene of living.

✲

L. Grant Baldwin, M. D. (595 E. Colorado Street, Pasadena).—The value to both mother and infant of a proper dietary management in pregnancy is too well established to be even slightly controversial. But what makes up a proper diet, for the average pregnant woman, has been a subject that has developed many fads and a few facts. Even our recent obstetric textbooks are extremely vague in their dietary advice. A statement—that the diet should be well balanced in its protein, fat and carbohydrate ratio; should contain ample vitamins and minerals; and should exclude certain known harmful substances, notably alcohol—is about all one will learn from such a source. If, as a profession, we were all well versed in nutritional studies, the above advice would perhaps be ample. However, most of us are not so skilled and practiced, and we find it difficult to convert this advice into a form that can be given to a patient with any assurance that she will in turn be able to put it into practice. In this excellent article Doctor Tollefson has given us many valuable facts, but above all he has done a great deal of thinking for us, with the result that we receive from him concrete advice that is in a usable form for clinical application. Today, with so many sources of poor dietary advice available to all who are prone to listen, this paper is particularly pertinent.

The routine use of Barboka's basic diet, with variations to meet different complications, is a long step towards a simplification of our obstetric dietary regimen. With this as a starting point, very few changes are necessary to convert a standard diet to one that is satisfactory for the obese patient, or the individual with early toxemia. In regard to Doctor Tollefson's advice as to toxemias, I am interested especially in his recommending a low fluid intake and no protein reduction. When Arnold and Fay published their work on the limitation of fluids in toxemias, in 1932, they created considerable discussion, for here an old standby, forced fluids, was being sacrificed. A complete change in our beliefs was asked, and naturally many of our profession could not be convinced that such a change was necessary or even wise. In this particular series the results seem to more than justify the change. My own experience with reducing the fluid intake in toxemias has been limited to a few mild cases, but the results have been uniformly successful. The maintenance of a normal protein intake falls into a similar controversial field, but if we listen to our medical colleagues we cannot but feel that here, too, we have a change based on a sound scientific background.

✲

Edward N. Ewer, M. D. (251 Moss Avenue, Oakland, California).—One finds many articles on isolated phases of pregnancy food problems, but few which cover the general subject for ready reference as does this one by Doctor Tollefson.

The outstanding fact which first brought prenatal care into such great prominence was the discovery that eclamptogenic toxemia can be nearly eliminated by keeping the pregnancy weight gain down to twenty pounds. Continued attention is necessary to keep the gain within this limit and still provide for all vitamin requirements.

It seems to me that vitamin A will need but little attention. If left to her own devices, the pregnancy patient will often gain thirty-five or forty pounds upon her own selection of high vitamin A foods, and yet her parturition infection hazard will hardly be less than that of her thinner sister. At the same time her overfed condition invites the danger of late toxemia. I find it necessary to reduce fats to a minimum in more than half of my patients, and I have seen none of the deficiency effects of a lack of vitamin A.

Probably we should give careful attention to the continual replenishment of vitamin B, for its storage capacity in the body is not great. It improves digestion, assimilation and peristalsis, and when adequate in amount, its antineuritic factors may have much to do with preventing vomiting of pregnancy.

The experiences of Luikart and of Plass with cases of polyneuritis, following hyperemesis, suggest to them the possibility that the vomiting of pregnancy may be an expression of B. avitaminosis.

I have had little success with high carbohydrate feeding, but have seen improvement with frequent small solid food meals containing all or any of the foodstuffs. We have all seen quick relief without medical or other treatment upon moving the patient to a hospital; and many who have been happy in their selection of other forms of suggestion are firm in their belief in the neurotic origin of pregnancy vomiting.

I agree with the author that the weight of the baby may be influenced by the mother's diet. This seems not to have been confirmed by animal experiments, but the experienced clinician will continue to obtain satisfactory results. Many years ago I became acquainted with Prochowinck's classic article, published in 1889, in which he proposed restriction of fluids, and a diet composed largely of nitrogenous foods and green vegetables, beginning in the seventh month. I have carried this out many times, usually because of a history of previous large babies, and the results have been good.

The work of Arnold and Fay indicates that the reduction of fluids in the last two months may be valuable in the prevention of eclampsia. Vitamin deficiencies of such a diet may be made up with commercial products as suggested by the authors.

"For every baby a tooth" was an almost expected sacrifice a few years ago. That dental caries was primarily a chemical process with only secondary bacterial invasion was unknown. Since we began giving so much milk, we hear less of tooth trouble, and now there is still further improvement, with the addition of calcium salts with viosterol to insure their utilization.

P. Vogt-Möller, of Copenhagen, reports twenty cases of habitual abortion treated with wheat germ oil (vitamin E and a moderate amount of A). A living child was obtained in seventeen out of the twenty cases. The preparation was first used hypodermically with apparent success by veterinarians in the treatment of cattle and dogs.

While most investigators doubt that vitamin E is ever deficient, this Danish observer suggests that such may be the case with some women, due to their increased metabolism during pregnancy.

RESECTION OF THE STOMACH FOR CARCINOMA—IMPORTANT TECHNICAL CONSIDERATIONS*

By Emile Holman, M. D.
San Francisco

Discussion *by Verne C. Hunt, M.D., Los Angeles; Ernst Gehrels, M.D., San Francisco.*

CANCER of the stomach, although a curable disease since Billroth's brilliantly conceived but unsuccessful first attempt in 1881, continues to be one of death's most powerful weapons. Wherever the disease occurs, be it Asia, Europe, or the Americas, statistics[1] indicate that from 38 to 52 per cent of all deaths from cancer are due to malignancy of the stomach (Table 1). By way of comparison, it may be noted that the next most frequently involved site, the female reproductive system, gives rise to only 15 to 25 per cent of all deaths from cancer. Equally startling is the fact that 50 per cent of all cases of gastric cancer are obviously inoperable, and therefore hopeless, when first seen. In less than half of the remaining 50 per cent who are operated upon is resection possible, and of these less than 20 per cent live longer than five years (Table 2).

EXPLANATION OF THE HIGH MORTALITY

The reasons for such a tragically foredoomed course are two-fold. First, the paucity and mildness of early symptoms fail to disclose the seriousness of the disease. As a corollary to this, is the universal tendency of both patient and physician to treat these early symptoms as due merely to "indigestion," "dyspepsia," or, at their worst, to "ulcer." Moreover, due to the mildness though persistence of the symptoms, the patient is buffeted about from one doctor to another until eventually there develops the characteristic picture of progressive loss of appetite and strength, emaciation, dehydration, anemia, and palpable tumor. It is a tragic fact that until the symptoms are thus stubbornly insistent, and almost blatantly evident, the patient and his physician often fail to recognize the need of more careful and more complete studies, and even the precise diagnostic aid of the x-ray is deferred until it is too late. The stark truth is that too often the physician is deluded into a false sense of security simply because his patient with persistent dyspepsia still *appears* to be in normal health, without anemia, without loss of weight, without palpable tumor, and with a normal gastric acidity. Such a patient may be cured of his disease, but either he is not offered the opportunity by his physician, or he refuses to accept it when so offered because he still feels too well.

Equally disastrous is the assumption, when ulceration is present and proved, that it is peptic and not neoplastic in origin. The symptoms are often indeterminate and inconclusive. The pain, present for two, three, four, or even seven years, may be definitely related to meals, and be relieved by soda, or eating, may show remissions of greater or lesser degree and duration over a period of years, may show a normal range of gastric acidity in normal volume, may present the radiological appearance of ulcer; and yet the apparent innocence of all this evidence is belied by ultimate death from cancer.

WHEN RESECTION SHOULD BE PERFORMED

Under what conditions, then, should resection of the stomach be performed? Any corporic ulcer situated elsewhere than on the lesser curvature demands removal. Experience has shown that ulcers of the greater curvature, of the posterior or anterior wall, situated well away from the so-called "magenstrasse," are in the great majority of instances due to cancer. Prompt recognition of this fact will permit operation at an operable stage.

In addition, ulcers of the lesser curvature and pyloric region, which fail to show regression in size following several months of a strict dietary and hygienic régimen, must be resected. Mere re-

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TABLE 1.—*Cancer Mortality According to Organs (F. L. Hoffman)*

	U. S. A.	Canada	Holland	England	Japan	Spain	Singapore	Chile
MALES								
Stomach	45.2%	46.4%	64.0%	36.8%	83.4%	49.0%	66.7%	59.9%
Intestines	14.7	16.1	13.0	23.6	5.7	6.2	6.1	1.9
Buccal cavity	6.3	7.8	3.4	10.8	3.4	7.5	5.1	2.0
FEMALES								
Stomach	30.5	31.1	47.2	26.3	52.5	33.6	31.2	47.3
Genital tract	24.1	19.2	13.4	20.6	32.8	20.3	28.2	15.4
Breast	16.1	17.6	13.8	19.1	3.0	7.0	16.7	2.0
Intestines	14.4	15.6	14.8	20.6	5.6	7.2	6.4	3.7

mission of symptoms under such care is not sufficient reason for continued conservatism. There must also be a definite diminution in the size, and eventual disappearance, of the ulcer. *A persistent ulcer on the gastric side of the pylorus must be removed.*

THE EARLY DISSEMINATION OF THE CANCER CELL

The second important factor in the woefully discouraging results obtained in the surgical care of this disease is the early and widespread dissemination of the cancer cell. This is undoubtedly the direct result of the vigorous peristaltic massage to which tumors in this organ are constantly subjected. In experimental animals even very limited massage [10] of a malignant tumor doubled the number of metastases found at death. Small wonder, then, that the active peristalsis of the stomach, which continues with unrelenting vigor day in and day out, should lead to abundant and early metastases. The natural corollary to this early spread of the cancer cell, from the stomach to the glands of the lesser curvature and of the coeliac axis, is to increase enormously the technical difficulties of surgically eliminating the original growth and its extensions.

Certain authors allege that removal of the main growth, with incomplete removal of presumably involved glands, has nevertheless resulted in a cure. These assertions obviously cannot be proved, and such claims only serve to dull the conscience of the surgeon who is encouraged to leave behind involved glands in the hope that they will disappear. When such apparently miraculous cures do occur, the explanation lies in the fact that glands enlarged by inflammation are indistinguishable from carcinomatous glands, and therefore may *seem* to be involved, but actually are not.

LESSER CURVATURE CARCINOMATA

The most difficult extension to encircle by excision is that along the lesser curvature. Many specimens observed in the pathological laboratory following resection of the stomach show clearly that the operator "hedged" in his efforts, and that, faced by an enhancement of his already difficult task of reëstablishing the continuity of the bowel, he cut dangerously close to, or through cancer. Ideally, with respect to cure, the *first* requisite in any operation for cancer should be total removal of the growth, and the *second* requisite, reëstablishment of the gastro-intestinal canal. Too often

TABLE 2.—*End Results of Surgical Treatment of Gastric Cancer*

Surgeon	Locality	Number of Cases	Exploration	Resection	Probable Cures
Walton [2]	London	262	171	91	9
Saltzstein [3]	Detroit	365	96	28	11
Lahey [4]	Boston	168	62	56	9 lived 2 years and longer
Balfour [5]	Mayo Clinic	3,200 (approx.)	1,600 (approx.)	640 (approx.)	128 (4 per cent)
Oughterson [6]	New Haven	120	60	19	4
St. John [7]	New York	230	75	32	9
Cheever [8]	Boston	236	77	23	3 cases lived 5 years
Persson [9]	Stockholm	1,150	789	361	*53 lived 3 years *39 lived 5 years 17 lived 6½ years and longer
	Total	5,731	2,930	1,250	190

* Died of cancer of stomach.

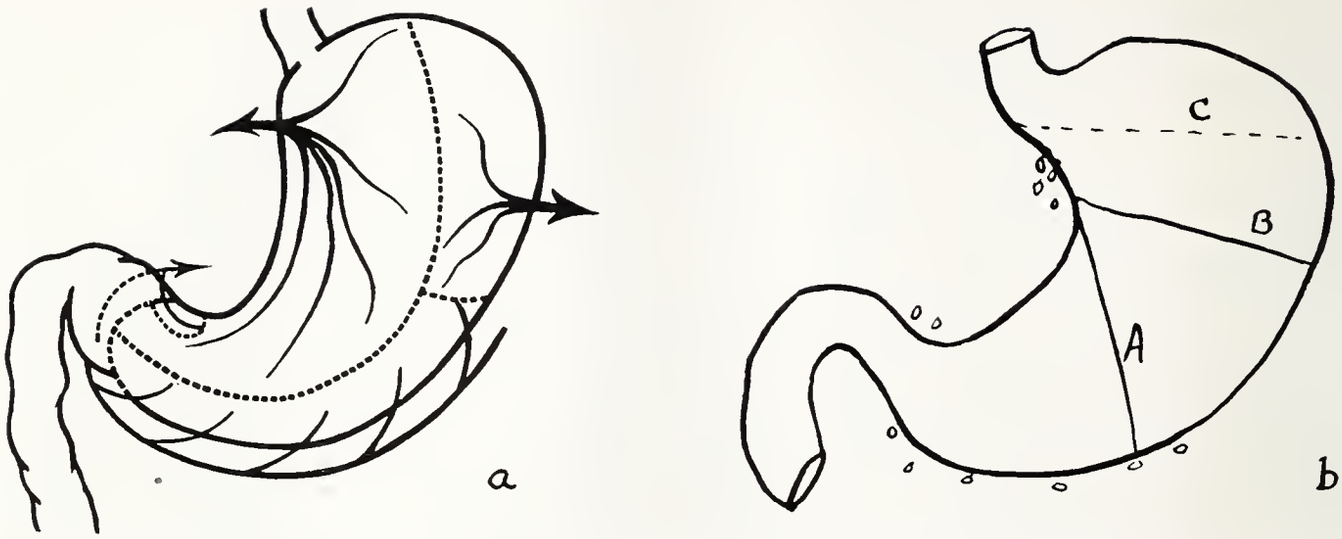


Fig. 1.—(a) Lymph channels of stomach according to Cuneo. (b) Resection of stomach along lines A and B transverses potentially involved lymph channels. Subtotal resection along line C is advocated for all gastric carcinomata.

the first is "trimmed," to insure the latter. In this connection, may I quote the late Doctor Halsted of Baltimore, who asserted (with particular reference to carcinoma of the breast) that the surgeon who removes a cancerous growth should not be responsible for the subsequent closure of the wound, thus eliminating the temptation to "hedge" as to the extent of the excision of skin.

Approximately 38 to 40 per cent of all carcinomata of the stomach involve or lie along the lesser curvature. The lymphatic drainage of this region, according to the classical description of Cuneo, ends predominantly in the glands lying at the gastro-esophagael junction (Fig. 1-a). Resection of the stomach, according to the usually described methods along the lines of either A or B, is obviously inadequate (Fig. 1-b). To be sure of removing all presumably involved lymphatic channels and glands requires a very complete resection of the lesser curvature, even though the original growth is limited to the pyloric end. Such a resection may be termed "subtotal," and a *subtotal* gastrectomy is advocated for every operable gastric cancer as providing the best means of eradicating the disease. No surgeon considers amputation of the breast, without inclusion of the regional lymph channels and glands, as a justifiable procedure, except for purely palliative purposes. Similarly, cancer of the stomach should be treated by the most radical operation designed to eliminate regional lymph channels and glands.

Logically, it might be argued that a total gastrectomy is the ideal procedure. However, in many instances its performance is technically impossible, whereas the subtotal gastrectomy is feasible. Moreover, an even more complete resection of the lesser curvature may be performed in the subtotal than in the total gastrectomy. To insure success in the latter procedure, there must be available a good stump of esophagus below the diaphragm for purposes of anastomosis. In the subtotal gastrectomy resection of the lesser curvature may be carried to the diaphragm.

TECHNIQUE OF GASTRIC RESECTION

The technique of gastric resection for gastric carcinoma may be briefly described as follows: Preoperative preparation over a period of several days consists of gastric lavage for retention, and correction of dehydration by daily hypodermoclysis of five per cent glucose in normal saline, and by rectal instillations every four hours. The patient is typed and matched for transfusion. A hypodermoclysis is begun two hours before operation and continued throughout the operation. The administration of barbital and sodium bromid the night before and on the morning of operation, supplemented by morphia and atropin, usually permits the performance of the entire operation under nitrous oxid and oxygen anesthesia.

A midline incision is made to permit opening the abdomen as high as the ensiform cartilage, thus permitting readier access to the esophageal opening. If resection is considered advisable and feasible, depending upon absence of metastases and fixation, mobilization is begun opposite the pylorus by division of the gastrocolic omentum. Great care is observed to avoid injuring the branches of the pancreaticoduodenal artery and its easily ruptured accompanying veins. Sharp and blunt dissection of areolar tissue between the pylorus and underlying pancreas, with division of the gastrohepatic omentum, permits mobilization of the pyloric end of the stomach. This mobilization is continued beyond the pylorus sufficiently far so as to enable one to apply two Payr clamps on the duodenum itself for division between them. The duodenum is closed by the application of the Parker-Kerr continuous stitch of catgut, which is in turn inverted by interrupted black silk sutures. A peritoneal fold is sutured to the line of closure; or, when feasible, the stump is approximated to the surface of the pancreas, burying the line of closure. The division of the gastrocolic omentum is continued to the cardia on the greater curvature, and of the gastrohepatic omentum to the esophageal opening on the lesser curvature,

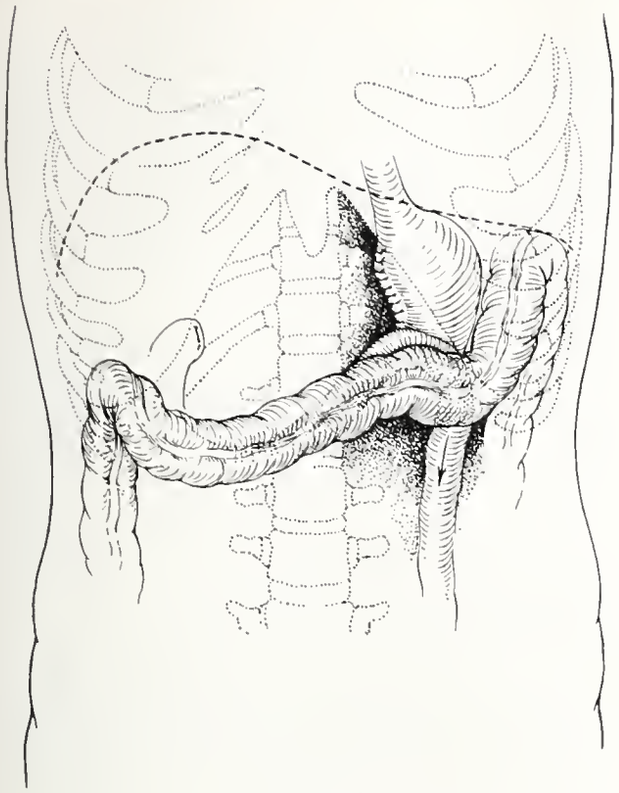


Fig. 2

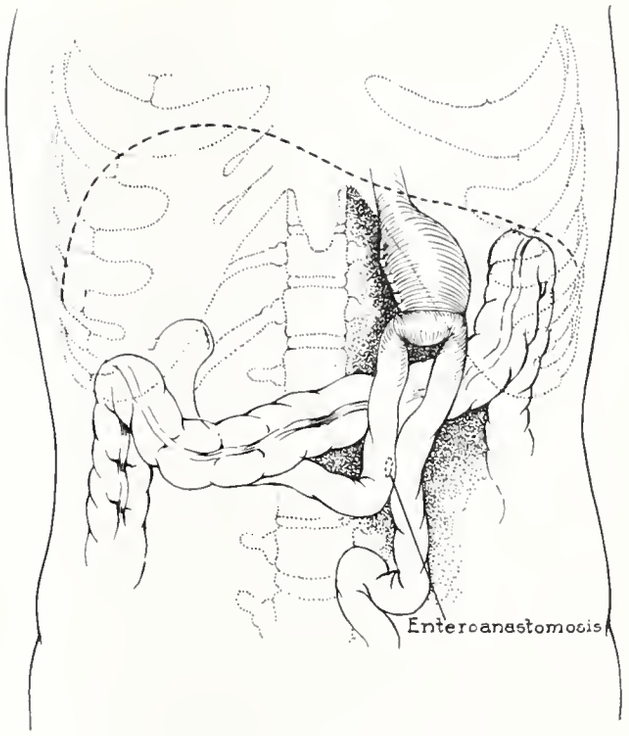


Fig. 3

Fig. 2.—Diagrammatic construction of tube from cardiac stump of greater curvature following complete resection of lesser curvature, and reëstablishment of continuity by a retrocolic gastrojejunostomy.

Fig. 3.—A high-lying stump of stomach, or a low-lying mesocolon, demand an antecolic gastrojejunostomy supplemented by a jejunojejunostomy.

every effort being made to include all palpable and visible glands. Mucosa clips are applied to the lesser and greater curvatures above the line C (Fig. 1-b), and the stomach wall cut across. All bleeders are caught in clamps and ligated individually. With a curved needle and chromic catgut, a continuous suture is applied, beginning at a point just below the esophagus and continuing along the line of incision until all but two inches are closed. This continuous suture line is inverted by interrupted black silk suture. This tube-like structure, fashioned from the stump of greater curvature, is then implanted in the wall of the jejunum by an end-to-side anastomosis (Fig. 2).



Fig. 4.—Roentgenogram following subtotal gastrectomy and antecolic gastrojejunostomy. Remnant of stomach following subtotal resection is indicated by the two dark lines at the top of the illustration.

DECISION ON TYPE OF FURTHER PROCEDURE

A decision vital to the success of the operation must be made at this point: whether to perform this end-to-side anastomosis posterior or anterior to the transverse colon? If the newly constructed tubular stomach recedes into the left upper quadrant, and does not easily reach the mesocolon when the latter structure is brought out at right angles to the longitudinal axis of the body, the anastomosis must be made anterior to the colon. If this precaution is not observed, the recession of the gastric stump into the subphrenic region will cause angulation of either the proximal or distal arms of the jejunum as they are pulled up through the rent in the mesocolon, and death from duodenal dilatation will occur (Fig. 3). Such angulation of the jejunum is the most serious and most frequent complication of the posterior Polya anastomosis. Therefore, if it seems imminent, an anterior or antecolic union is made with the additional safeguard of a jejunojejunostomy between the two arms of the jejunal loop (Fig. 4).

Technically, a dependable junction between stomach and jejunum is largely dependent upon one fact—the absence of tension at the site of anastomosis. Any drag or tension at the line of

union will result in leakage, peritonitis, and death. The sine qua non of intestinal surgery may be epitomized as "junction without tension." Accordingly, care must be observed in either the retrocolic or antecolic procedures, to avoid tension on the line of suture.

IMPORTANCE OF ABSOLUTE HEMOSTASIS

Another important factor for success in the formidable operation of gastric resection depends upon the avoidance of blood loss at the operating table, and absolute hemostasis of the individual bleeding vessels so as to prevent subsequent secondary hemorrhage. Patients already suffering from a moderate or severe secondary anemia cannot endure much loss of blood, either at the operation or subsequent to it. Immediate and secondary hemorrhage along the cut edges of the stomach is avoided by applying ligatures directly to the cut ends of individual vessels. To rely upon continuous anastomosing sutures to control hemorrhage as well, is inviting trouble, both from hemorrhage and from abscesses along the line of suture at the site of hematomata. Every effort is made, therefore, to control bleeding by direct ligation of each individual vessel.

If a retrocolic anastomosis has been performed, the rent in the mesocolon is sutured to the stump of the remaining stomach. Careful inspection of the operative bed for possible bleeding points completes the operation. The most frequent postoperative complication is distension of the stomach. A small tube is introduced through the nose into the stomach, and left for several days until all danger of retension is past.

SUMMARY

Gastric carcinoma the world over heads the list of all deaths from cancer. Although surgical removal is at present the only available method of cure, it can be applied in less than a fifth of all cases, and cure can be hoped for in less than a fifth of these, or about 3 to 4 per cent.

The reasons underlying these tragic facts are:

1. The paucity of early symptoms, and the general tendency of both patient and doctor to attribute them to "indigestion," "dyspepsia," or at their worst to "ulcer."

2. The early spread of cancer beyond the confines of the stomach wall due to its incessant peristaltic movements.

3. The technical difficulties of resecting such extensions once they have passed beyond the stomach.

Whenever feasible, therefore, subtotal gastrectomy with complete resection of the lesser curvature is advocated as the method most likely to insure complete removal of the original growth and the involved lymphatic channels and glands. Formation of a small tube-like stomach from the remaining greater curvature permits reëstablishment of gastro-intestinal continuity by end-to-side anastomosis with the jejunum.

A retrocolic anastomosis is preferable, but no traction at the site of union by the mesocolon is permissible, and when imminent, should be avoided by an antecolic gastro-enterostomy, supplemented by a jejunojejunostomy. Avoidance of bleeding at the operation, and complete hemostasis by direct ligation of all individual bleeding vessels, prevent embarrassing postoperative complications.

To improve our results in the treatment of gastric cancer it is advocated:

1. That every "corporic" ulcer located off the lesser curvature be treated from the moment its presence is demonstrated, as probably neoplastic in origin and therefore subject to subtotal resection.

2. That every gastric ulcer on the lesser curvature be resected, if two months of well controlled medical care do not both relieve symptoms and cause a diminution in the size of the ulcer, with ultimate disappearance of the ulcer.

Every ulceration on the gastric side of the pylorus, accompanied by symptoms that persist in the face of medical care, should be considered as probably neoplastic in origin and therefore subject to resection. It cannot be emphasized too strongly that the absence of anemia, weight loss, and palpable tumor, and the presence of a normal gastric acidity are not incompatible with gastric cancer.

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DISCUSSION

Verne C. Hunt, M. D. (727 West Seventh Street, Los Angeles).—Doctor Holman's urgency for surgical consideration of gastric ulcer, at or about the lesser curvature of the stomach, is worthy of emphasis. The differential diagnostic difficulties between a benign ulcer and a malignant lesion of the stomach are not always easy nor accurate. There are many lesions of the stomach in which the correct diagnosis may be established only through exploration and competent microscopic study of the lesion. The roentgenologist may localize the lesion and express an opinion on the

nature of the lesion, in which it may be proved that he is correct in a majority of instances; but, as Dr. K. S. Davis has expressed it, roentgenologic procedures do not include microscopic projection of a section. The competent pathologist is indispensable if, in the future, the diagnosis of early malignancy of the stomach is going to be arrived at with increasing frequency. This statement infers the early exploration, in the absence of contra-indications, of all depicted or suspected ulcers or ulcerating lesions. It is well known that some benign ulcers of the stomach will heal under medical management, but to be certain of the accuracy of the diagnosis of a benign ulcer is most difficult. The so-called therapeutic test has had many advocates in recent years, and has likewise allowed not a few apparent operable lesions to become inoperable during the period of observation, largely through failure of the physician or patient to adhere strictly to the principles of the therapeutic test.

I personally question very much whether extension of the height of the resection in the performance of partial gastrectomy for gastric carcinoma is the solution of the problem of increasing the actual number and percentage of cures of cancer of the stomach. It is difficult for me to agree entirely with Doctor Holman when he applies to the stomach and the regional glandular involvement of gastric carcinoma, the accepted principles of dealing with carcinoma of the breast. Limits of operability of carcinoma of the breast are determined in part by the absence or presence of glandular involvement beyond the axillary space. The limits of regional glandular involvement are much more easily determined in carcinoma of the breast than in carcinoma of the stomach. As in carcinoma of the breast or elsewhere in the body, the prognosis is dependent upon a number of factors, of which glandular involvement is important. Considerable data is at hand to indicate that in addition to glandular involvement, the type of lesion, whether sessile, ulcerating, polypoid, or perforating, or whether it involves the serosa and, most important, the degree of malignancy, exerts a profound influence over postoperative longevity. The removal of all glands along the lesser curvature in carcinoma of the stomach is highly desirable in all cases, irrespective of their involvement, if the primary lesion is operable and resection is possible. It is quite probable that the removal of all glands along the lesser curvature will result in a higher percentage of cures; however, I am not quite prepared to accept the recommendation of resection of the entire lesser curvature, simply for the removal of regional glands in those cases in which the growth is confined to the pyloric third, and in which a resection wide of the lesion may be made within a justifiable mortality rate. It is the extension upward of the resection along the lesser curvature that builds mortality, and in even most skillful hands this rises rapidly above the middle third of the lesser curvature. Furthermore, the operability of gastric carcinoma above the middle third of the stomach is extremely low, not only through regional glandular involvement, but through fixation and extra-gastric extension or metastasis. Doctor Holman's procedure approaches radical total gastrectomy. The applicability of the latter procedure is but occasional, and its mortality rate has been conservatively reported at 60 per cent. It is my opinion that hope for the future in the cure of carcinoma of the stomach lies in the performance of semi-radical partial gastrectomy within a reasonable and legitimate mortality rate in an increasing number and percentage of early gastric lesions, rather than in extending the height of gastric resection for extensive disease in which factors other than glandular involvement are still beyond control. I wish to commend Doctor Holman on his enthusiastic activity toward improvement in the results in the surgical treatment of gastric carcinoma.

Ernst Geihels, M. D. (490 Post Street, San Francisco).—This section is greatly indebted to Doctor Holman for pointing out the inadequacy of our present surgery for cancer of the stomach. It is customary to attribute the bad results to the delay in diagnosis by the general practitioner, while as a matter of fact, inadequate surgery is just as much to be blamed. There are too many exploratory laparotomies on the records of the operating rooms. The 25 per cent resections which should be the average are not nearly achieved in most hospitals.

Far too many gastro-enterostomies are performed for cancer. Gastro-enterostomy very rarely has a place in the surgery of cancer of the stomach. Cases of mild obstruction with a small six-hour residue, usually cancers of the lesser curvature, are not benefited at all by gastro-enterostomy. A palliative resection, in spite of a few small metastases or irremovable glands, will give the patient much greater and longer benefit. Two-stage operations should not be done. The operator who does a gastro-enterostomy and plans to do a resection a few weeks later, is making a mistake. If he undertakes partial gastrectomy, after a short while, two or three weeks, he will find the gastric wall edematous and brittle. If he lets six weeks or more elapse after his gastro-enterostomy, he will often find the cancer rapidly grown. This applies also to Balfour's method of two-stage resection.

The immediate success of partial gastrectomy depends on the avoidance of the following main dangers:

1. *Pneumonia.*—As an anesthetic, I consider avertin combined with gas the best at the present time.

2. *Operative Peritonitis.*—This should be rare. It is important to avoid all soiling of the operative field in cancer cases. For this reason I prefer using clamps for the anastomosis.

3. *Gastric Ileus.*—You will probably never see it if you use the Polya type of resection with a long antecolic loop and entero-anastomosis, as Doctor Holman has advised. It should become the standard method in cancer. Not only is it safest against mechanical ileus, but the anastomosis prevents retrograde filling of the duodenum and, therefore, protects the duodenal stump. In doing the anterior Polya, I find it better to have the loop leave the stomach at the lesser curvature. You will find that there is less torsion of the loop if done in this manner. If ileus symptoms should occur and persist in spite of the usual treatment by lavage, etc., do not hesitate to give the patient a small barium meal. It will enable you to know whether one is dealing with atony of the stomach, demonstrated under the fluoroscope by entire lack of peristalsis, or mechanical obstruction, showing in the fluoroscope by excessive motility. In the first case, Connell suction and possibly a jejunostomy is all that is necessary. In the other case, of mechanical ileus, the situation is much more difficult and requires immediate re-laparotomy.

Regarding the height of the resection, I have been individualizing. I find it valuable to immediately inspect the resected tumor during the operation. If the resection has been rather close to the tumor, additional tissue should be excised. It is quite difficult to extend the line of resection to the cardia if the stomach is high under the costal margin, and cannot be delivered sufficiently. In cases of ptosis, a high resection may be fairly easy. All cases with extensive glandular involvement have a poor prognosis in my experience; recurrence has usually been quick even after a very radical removal.

In closing, let me say that results of partial gastrectomy are not quite as discouraging as the four per cent permanent cures that Doctor Holman mentioned would indicate. Recurrence after a well-performed partial gastrectomy is often long delayed. Perfect well-being over a period of two years or more is achieved in a considerable number of cases.

URINARY CALCULI, CAUSE AND TREATMENT*

By Miley B. Wesson, M. D.
San Francisco

WE are all particularly interested in preventing the formation of stones in two types of patients—those from whom stones have been removed by operative means (open or cystoscopic), and those who have spontaneously passed their calculi. In this paper we are not concerned with bladder stones or with any theories concerning whether or not the stones are formed in the kidney and drop in the ureter; or whether they are formed in the ureter above strictures, and regurgitate into the kidney pelvis.

So far this year I have attended five medical conventions, and at each one a day was devoted to papers on urinary calculi. This I interpreted to mean that scientific urologists are not satisfied with the therapy they are using in the treatment of bacilluria and the prevention of stones. I am bringing to you neither a report of original work nor a series of spectacular cures by new methods; for so far I have been unable to make all my patients behave and stop forming stones. I am merely going to pass on to you the information I have collected, and tell you how I intend to treat my patients during the coming year.

The American Urological Association annually has an outstanding man deliver the Ramon Guiteras Lecture, named in honor of their first president. This year our guest speaker was J. Swift Joly of London, England, and the title of his paper was "The Etiology of Urinary Calculi." In this address he clarified, but added little or nothing new to our knowledge. We are all familiar with the theories of stone formation—nuclei, bacterial, supersaturation, and obstruction. We also know that crystalloids or true colloids exist in the urine as normal constituents, and have a direct effect on the highly insoluble urinary substances; furthermore, that interference with the surface tension of the mucous membrane, which is normally zero, will encourage stone formation. As the matter now stands vitamin deficiency, poor hygiene, an indeterminate colloidal unbalance in the urine and infection seem to be the causal factor in calculus formation. Urostasis, while not a cause in itself, certainly favors the process, and by keeping up infection, is one of the most important factors in recurrences.

Dr. J. Dellinger Barney and his co-workers at the Massachusetts General Hospital still believe that stone formation and parathyroid tumors are closely associated. The blood calcium content, which is normally 9 to 11 milligrams per 100 cubic centimeters, becomes as high as 18 to 25 milligrams; and this elevation is pathognomonic, since the calcium blood content is not raised by anything but a parathyroid tumor. Their findings are startling. Doctors Lower and Higgins of the Cleveland Clinic expect much from the high vitamin acid ash diet, while those who follow the teaching of the Mayo Clinic are interested in the preventive therapy advocated by Dr. L. D. Keyser of Roanoke, Virginia, and the simplified ketogenic diet of Dr. A. L. Clark of Oklahoma City, with the addition of beta-hydroxybutyric acid by mouth, to increase ketosis, as advocated by Dr. Henry Helmholz.

PREVENTIVE MEASURES

We are all familiar with the five standard, I might almost say axiomatic, preventive measures that must be carried out if we do not want urinary calculi: (1) Prevent urinary stasis by providing adequate drainage, and not only will stones not form, but kidney infection will clear up without cystoscopic lavages, etc., the irrigating being done by nature from above. (2) All metabolic errors should be remedied by the use of cod-liver oil, etc., for unless there is a deficiency of vitamin A, there will be no xanthin, cystin or urate stones formed. (3) Remove specific infections, for if the urea-splitting organisms are not present, there will be no formation of phosphate or carbonate stones. (4) Eliminate focal infections. Rosenow and Meisser found that if they took streptococci from the urine of a stone-carrier and injected them about devitalized teeth, renal calculi would form in the subject. (5) Antiseptics have a therapeutic place, provided they do not interfere with digestion and the general well-being of the patient.

KINDS OF STONES

The stones that plague our patients are commonly carbonates, whereas in England phosphates predominate. Cystoscopic lavages of ½ per cent hydrochloric acid, or 1 to 2 per cent phosphoric acid, have been respectively used to dissolve the stones. The maneuvers have been without result in my hands, aside from making the patients very, very sick.

Theoretically, hexamethylenamin breaks down to form formaldehyd and thereby sterilizes an infected urine. We all know that the drug does not act without the urine is acid. Acid sodium phosphate has been widely used in conjunction with urotropin, under the impression that it produced urinary acidity; but instead, it usually merely causes gastric disturbances or a diarrhea. This drug is an acidifier only when the urine is very alkaline. Litmus paper is the common indicator used. Dr. Hugh Cabot, at a recent meeting of the California Academy of Medicine, stated that litmus paper was absolutely valueless as a test for the acidity of urine, and that Medicine needed a General Hugh Johnson to prohibit its use. Methyl red indicator is accurate, since it is definitely red when acid (*i. e.*, p_H 5.5 or less) and yellow when alkaline.

It has been established by Osterberz and Helmholz that ketone-urine with a p_H value of 5.5 or less, and a concentration of beta-hydroxybutyric acid of 0.5 per cent or greater, will have a bactericidal action on the commonly encountered strains of Escherichia coli found in infections of the urin-

* Read before the Nevada State Medical Association, at the Bowers Mansion, September 21, 1934.

ary tract. The higher the concentration of beta-hydroxybutyric acid, the more bacteriostatic the urine. Helmholz has found that it is possible to increase the content of the urine above the necessary 0.5 per cent by feeding this drug. There are two objections to its use. The drug is difficult to procure, costs 60 cents a gram, and the dosage is two grams three times per day in capsules. Furthermore, if the patient is not in a state of ketosis, the drug is oxidized to carbon dioxid and water and the $3.60 per day is wasted.

KETOGENIC DIET

If the ketogenic diet is used, it should be given at weekly periods alternating with mouth antiseptics. Ketosis should develop in three to five days; if not evident in from eight to ten days, further effort will probably be unsuccessful. The rule at the Mayo Clinic is not to give oral medication unless adequate acidification of the urine, pH 5.5 to pH 4.6, fails to develop with ketosis; then give ammonium chlorid or ammonium nitrate in 7½-grain enteric coated pills. Use 15 to 30 grains four times per day in conjunction with 15 grains of hexamethylenamin. In passing, I might state that there are some chocolate resin coated pills on the market labeled "enteric coated," but the Mayo Clinic finding these unsatisfactory had made, on special order, salol-coated pills and these are yellow. They can be procured in Rochester and in San Francisco. It is important to use both ammonium chlorid and ammonium nitrate pills; as some individuals, for no apparent reason, produce a greater degree of acidity with consequently a lower pH value in the urine on one pill than they do on the other. Therefore, switch the drug if a high acid reaction is not obtained. Also occasionally, the ammonium nitrate pills cause nitrite poisoning of a mild form, which greatly weakens the individual, causing diarrhea and among other things cyanosis.

HIGH VITAMIN ACID ASH DIET

At the Cleveland Clinic they use the high vitamin acid ash diet routinely on all stone cases. They consider it invaluable in their inoperable bilateral stone cases, stone formers, and orthopedic cases which are immobilized for long periods of time due to fractures. During the past two and one-half years, they have used it as an adjunct in the treatment for the prevention of postoperative calculi formation. They like to keep the pH of the urine around 5.2 to 5.4 for a period of at least six months after operation. Doctor Higgins writes me that a study of his follow-up letters shows six cases in medical professors who were chronic stone formers, but have had no stones for two years. In two instances the stones were uric acid in type, and in the remaining group a mixture of calcium phosphate and oxalate. He has records of eighteen cases of stone in the kidney which have completely disappeared under this diet, and several more that show stones decreasing in size. In only one case was there a recurrence, and that patient did not follow the instructions or return for observation.

Apparently, it is far more important to keep the urine highly acid, so as to encourage the dissolving of the stones and the destruction of the bacteria, than it is to use bacteriophage or bacteriostatic drugs. Hence, in this paper, I am not considering the value of intravenous neosalvarsan, mercurochrome, acriflavine, etc., or the oral ingestion of the various dyes such as niazo, serenium, etc.

IN CONCLUSION

In our youth, we implicitly believed that stones could be prevented by decreasing the calcium intake through drinking only distilled water, and restricting diet to those articles that had a low mineral content. Of course this is nonsense; but who among us has not empirically treated pyelitis and cystitis in both children and adults by "salting out" the bacteria. We first gave baking soda to alkalinize the urine, and then alternated with sodium acid phosphate and urotropin in ineffectual doses. We still smile when we think of our gullible forbears wearing asafetida bags about their necks to cure their colds, and carrying buckeyes in their pockets to ward off rheumatism, or even putting pans of boiling water under the bed to prevent night sweats, while we persist in the use of alkalis, as did our fathers, for a trigonitis due to an infection, when instant relief usually follows reducing the pH of the urine to 4.6. Chemistry is at last coming into its own.

490 Post Street.

THE LURE OF MEDICAL HISTORY*

THE HEALTH FOUNDATION FOR RECOVERY†

By Haven Emerson, M.D.
New York City

I

AFTER listening to the reports of the science and art of public health practice presented to the American Public Health Association in these past four days at Pasadena, by health officers and students of preventive medicine from our own and neighboring nations, it is quite inevitable that I should come to you brimful of optimism and self-confidence.

Something of the courage and hopes of these devotees of science I would convey to you here, because it seems to me that in the experience and accomplishments of this, the youngest of the standard functions of civil government, there are lessons for other undertakings, both private and public; and because the record of human life in our own states and insular possessions during these past five years of economic confusion, fear,

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

† From the De Lamar Institute of Public Health of Columbia University, New York City.

Read on September 8, 1934, at San Francisco, before the Commonwealth Club.

and sometimes despair, has been one of unparallelled excellence and unprecedented progressive annual improvement.

GROWTH OF CIVILIZATION IS INTERMITTENT

Civilization has never been continuous or a matter of uninterrupted growth, but rather an intermittent and recurrent phenomenon. Looking back into the gradually clearing record of other continents and different races, we are convinced by the archeologists and historians that, of the eight successive periods of civilization in the past ten thousand years, the intervals of barbarism have been growing shorter and the distances between them of longer duration. But a striking experience of the present era of the occidental nations, as well as for us a most encouraging event, has been the application of natural forces to add materially to man's security and to his longevity. Since about 1500, when the latest wave of emergent civilization began in Europe, and particularly in the past hundred years, man has found his greatest triumphs in mastering the forces of nature, and to such a degree that he can at last indulge in realistic plans for a controlled society and a predetermined reproduction of his kind.

The question as to whether we are now about to revert to a new phase of barbarism, or are likely to advance further into a higher civilization, appears to depend more upon our wise and honest reading of the lessons of biology than to await the possession of more power of wealth, more land, or more property or capacity of production.

Progress occurs as the result of strife, and it is for us to choose whether this will be with nature or with man. There is a practical nobility in man's struggles with nature, his striving to understand and reconcile nature's laws with man's ambition for survival, and supreme enjoyment of his superiority of mind over other living things. This is lacking in the invasions of men by force, in recurring wars of replacement and destruction of races and governments.

A PRESENT-DAY PHILOSOPHY OF SERVICE

In general the philosophy of those serving you, taking part in the active development of civil government today as protectors of the public health, is that of pacifism, a term often bandied about with abuse and misunderstanding. As this term should be understood, it implies a devotion to that knowledge which contributes to the security of individual and collective human life, as distinct from a worship or use of force and power to compel man to be subservient to man.

The dominant preoccupation of men's minds today is no longer fear of nature, but fear of each other.

A recent bulletin of your State quoted a famous sanitarian of Canada to similar effect:

"So, very, very slowly, with many a slip and a stumble, and many a scar to show for early errors, mankind has reached the point where nature is no longer a thing to fear, no longer a thing to fight, no longer a thing to conquer, even, as a rebellious slave; but rather a bountiful mother, to be studied, understood, coöperated with—blood of our blood, bone of our bone, literally as well as metaphorically—and harmful to us only when we fail to understand, or venture rashly into foolish feats."

APPLICATION OF IDEALISTIC PHILOSOPHY TO PRESENT-DAY CONDITIONS

You may well ask what idealistic philosophy has to do with you, your present dilemma of commerce, government, the professions, and the arts. Permit me to answer you by a brief description of our national population and its more recent reaction to a quinquennium of meager years.

To begin with, we are a decidedly aging, or shall we say, a maturing population. This is clearly revealed in an increasing disproportion between grandchildren and grandparents. There have never been in our history, and probably not in the records of any comparable population group so many adults in proportion to minors, or in other words, so many persons who may be taxed to provide schooling for so few children.

HOW THE PROPORTION OF ADULT AND CHILD POPULATIONS HAVE CHANGED

In the first trustworthy state census of New York in 1855, 14 per cent of the population was under five years of age. We learn from the 1930 federal enumeration that this age group constituted but eight (7.7) per cent of New Yorkers today, and in California children under five are but seven (7.1) per cent of your population. Children under fifteen years of age in California constitute but twenty-three (22.8) per cent of your population today, while the earliest census of New York State recorded this group as one-third of the State's population. Fewer are born, more survive, and those who do live, live longer. This is both the cause and effect of striking changes in the prevalence of disease, and in the proportionate distribution of the different causes of death. Illnesses characteristic of childhood, youth and early manhood, are less common and less fatal than formerly, thus constantly adding to the actual and potential years of initiative and productivity. Disabilities of the later decades are more frequent in occurrence, and bulk larger each year among the causes of death. It is highly creditable to have achieved a health status of youth and early maturity which brings about a rising mortality from heart disease among the aged. In a people who have an average life expectancy of over sixty years, those natural terminations of life which happen after sixty are sure to be more frequent among us. With every drop in the infant mortality rate, every year of downward trend in tuberculosis, diphtheria and other acute communicable diseases of childhood, there is a rise in the proportion of those illnesses which terminate human life in the latter decades. This is as it should be; for it is the years from twenty to sixty that carry the world's load. It is these men and women, formerly lost by unnecessary disease and premature death, who do the work, accumulate reserves, save so that standards of living advance, provide for their own children, and set aside enough for their own old age.

HOW INCREASE IN LIFE EXPECTANCY HAS AFFECTED AMERICAN CIVILIZATION

It is primarily the increased amount and security of young and middle-aged adult life which preventive medicine has assured in the past fifty years that is responsible for the wealth and stability of our people today, perhaps also for some of our overproduction.

All this may be generally known to you; but what may have escaped your attention, in the midst of the pressing duties of a period of dislocation calling for unprecedented readjustments of thought as well as in finance and government, is that progress in human life saving, in life expectancy, in security for the future, has been uninterrupted since 1929, and in many respects has been at a more rapid rate than in any previous five-year period of our own national experience.

There is no better guarantee of national recovery than the excellent present state of health of the people of the United States.

There has been in the minds of many a very natural fear, widespread and persistent, that the children of today, especially those born and brought up in the past five years of general economic confusion, would presently reveal tendencies to ill health, defects of growth and nutrition, lowered resistance to infection, and an increase in death rate. Deficiency diseases have been looked for, and particularly has the shadow of impending tuberculosis been expected, in duplication of the experience in Germany in the deflation and collapse in 1923-1924.

And yet nothing of the kind has occurred among us. Although the tuberculosis death rate and the infant mortality rate in Germany almost doubled while the mark reached astronomic expressions of worthlessness in a twelve-month period, our people have had no such experience.

With each succeeding year since 1929, physicians in private and hospital practice, and health officers throughout our states have accumulated evidence that any such fear of ill health, as was bred of the German inflation, is unwarranted and groundless.

Year by year, from 1929 to date and including the experience of the last six months, all the trustworthy indices of national health have pointed to a steady and solid improvement. Among the reliable and delicate tests of change in the health status of a population are expectancy of life, general mortality, the survival of infants through their first year, the prevalence of certain preventable diseases of infection, and nutrition.

While calculations of life expectancy on a national basis have not been made for the past year, large samples of the wage-earning, or industrial population have been studied, and ample proof obtained that the average length of life, which had increased from about forty to fifty-nine years, from the time of the Civil War until 1920, has continued until at present it stands at about sixty-two years, the gains since 1929 being at no lower rate than those from 1920-1929.

Taking up again the subject of life expectancy estimated on a national basis, it may be said that the general mortality is lower today than at any time in our history, in spite of the increase in the proportion of our population of the upper decades of life which tends to raise the death rate.

INFLUENCE OF ADVERSE ENVIRONMENTS IN PREVENTABLE DISEASES

That preventable, communicable and curable disease which is most unfavorably and most quickly affected by any change for the worse in the nutrition, housing, and working conditions, particularly of city dwellers, is tuberculosis; and this has exhibited, since 1929, with unexpected regularity, an annual reduction in death rate of approximately 6 per cent per annum, each year being compared with its immediate predecessor. This fact alone should give confidence that the four basic necessities of modern man—food, shelter, clothing, and medical care—have been so universally provided for that damage has not resulted to health because of unemployment and restricted incomes. In fact, the very suspension of many a dusty trade and hazardous industry, the reduction of hours of work, the smaller number of men and women in factories, the diminished pressure for maximum production, have all contributed to a moderation in occupational hazards which has reduced the incidence and death rates from tuberculosis at every age, in all races, in both sexes, and in every area of the nation.

I do not claim that this has been due to new discoveries of science, greater skill or industry of physicians, or to more wisdom among the people; but it can be proved satisfactorily, I believe, that the economic catastrophe which has made anxious every thinking man from presidents to peons has not been responsible for damaged lives from tuberculosis, and that the simple truths upon which its control has been built have worked in years of adversity no less consistently than during fantastic prosperity.

There has been no relaxation in precautions by which water and milk are safeguarded, and consequently each year has shown new low levels of sickness and deaths from typhoid fever.

Diphtheria in the cities of the northern and central states and malaria in the southern have continued to shrink before the attacks which specific preventive and curative resources have put in our hands.

Pellagra has been cut almost in half since 1929 in many of our southeastern states by the application of the modern science of nutrition to specific deficiencies of diet, which for so long here and in many a foreign country have baffled statesmen and economists. In former periods of economic depression, and following floods, droughts, crop failures, insect pests, etc., pellagra commonly rose as a reflection of the impoverishment of large mountain and agricultural groups throughout the South. Knowledge and resourcefulness have prevented such experience in the past five years.

And, lastly, among the tests we may apply in order to judge of unfavorable trends in the health of the nation are those concerning infancy and childhood.

LESSER BIRTH RATE OF RECENT YEARS

True, the birth rate has fallen as never before in this country, and to a point in many states to threaten the permanence or balance of the population; but this has not been due to an inability of reproductive powers, an infertility of our races, or a failure of the most fundamental function of life. Rather, do we see in the falling birth rate a reasoned, rational self-control, a determination to have no more children than can be well provided for, a planning for family existence at a level acceptable to today's standard of education, culture and health. The national birth rate has fallen because we have sharply restricted immigration since 1914, and because there has been a widespread increase in the knowledge and use of contraceptive information, so that women of all classes and races can determine the frequency and conditions of motherhood for themselves, regardless of tradition, or of religious, social or emotional taboos. This voluntary control of parenthood is a sign of sound social health, not an index of racial impotence. Fewer babies will be born where most survive. The lower the infant mortality, the fewer babies will families need to continue the family. The greater the life expectancy of those born alive and surviving the first most hazardous year of life, the fewer will be the babies born. California has one of the lowest, if not at this time the very lowest birth rate of the states of the Union, and this, from obvious reasons, chiefly connected with the high average age of its population and the large numbers of its residents past the period of reproduction.

The babies born since 1929 have not only been fewer per thousand of the population, but more of them have survived than for any equal thousands of living births in our history. These babies have been less tainted with congenital syphilis, or hampered by a low level of nutrition than has been the case before, owing to the fact that the health guidance of the expectant mother has reached a high level of efficiency for a large share of the mothers of the land. In that perhaps most difficult population aggregate in this country, the metropolitan area of New York, last year there was an infant mortality of fifty per thousand and, as you must know, the west coast cities have made records down into the thirties, creditable beyond the fondest hopes of sanitarians but a decade ago. What do these figures mean in terms of national security? Merely that the family, the home, the elementary unit upon which any stable civilization and government is necessarily based, is safer and suffers less loss of child life than ever before, and this means large assets in social and political contentment even for those still waiting a return to the universal self-support and the respect of a permanent modest earning capacity.

PRESCHOOL AND SCHOOL CHILDREN

For the runabout, the so-called preschool child and the child of school age, the story is quite similar. There is no inconsistency in the evidence that malnutrition, which has always prevailed in homes of ignorance or destitution, has not increased in the United States in these past five years. Many of the states and numerous cities have, through their health departments, the medical profession, and the various private health agencies, studied the character and prevalence of undernourishment in children from two to sixteen years of age with surprisingly uniform results. California and New York had the same experience. New Hampshire, Michigan, and the Carolinas have all found the nutritional state of childhood to have been maintained on at least as high a level since 1929 as in the previous decade. This does not mean that we cannot find in some of our unfavored rural areas, and in portions of many of our industrial cities, children whose way of life, whose parents, and whose food, handicap their growth and development. Such is certainly the case, and too frequently so; but the American child, boy or girl, before and during the school period is as tall, as heavy, as active and fit at each age as was the case prior to 1929, and in many studies the children of the unemployed or otherwise temporarily dependent were better off as to growth and nutrition than previously. Childhood has suffered least, or not at all, and this was the opinion of a group of experts representing this and eight European countries under the auspices of the League of Nations in 1932. The cities of Paris, Amsterdam, Warsaw, Cologne, Budapest, Milan, and Prague have recorded lower morbidity and mortality rates since 1929 than in the last prior five-year period.

INFANT MORTALITY AS AN INDICATOR OF NATIONAL RECOVERY

You are concerned with trade balances, with relative values of the currencies of foreign and competing countries, with international debts—in short, with economic security and the sanctity of personal notes and national bonds. Permit me to suggest that at least as good a measure of national recovery, or the foundation for it, is the infant mortality rate. If England, the United States, Holland, Switzerland, Norway, lost but one child out of twenty, while Italy and Hungary lose twice as many, and France half as many more than we do, is there not good reason for confidence in the stability of those nations which count their human assets before all others, and in so doing best protect the tokens of exchange? If the tuberculosis mortality of young men and women between twenty and forty is nearly twice as high in Norway, Switzerland, Hungary, France, Italy and Austria as in England, Holland and the United States, shall we not include in our major sources of wealth, and as savings of real magnitude, the hundreds of thousands of lives we save from this disease?

(To be continued)

CLINICAL NOTES AND CASE REPORTS

IONIZATION TREATMENT IN HAY FEVER

By G. W. Walker, M.D.
Fresno

IN the March, 1934, number of the *Laryngoscope,* Warwick reported fifty cases of hay fever and other allergic manifestations treated since 1927 with, I think, better results than have been gotten from any other method of treatment. Some authorities fear that there might be destruction of the ciliated epithelium in the nose from ionization, but that has not proved to be the result. Alden, in the Barnes Hospital in St. Louis, has been using this method, if I mistake not, for two years, and is enthusiastic about it; and he can well be, from the results I have observed in his patients.

Our own cases date back only to June 15, 1934, and now we use ionization as the treatment of choice in all cases of hay fever—both true pollenosis and the all-year type, pollen asthma and vernal conjunctivitis. In cases of asthma which are not accompanied nor preceded by hay fever, our results have not been uniformly en-

Table 1.—*Results from Ionization Treatment in Hay Fever and Asthmatic Patients.*

Case	Date 1934	Age	Duration	Form	Previous Treatments	Number Treatments	Results
1	6/15/34	48	Hay fever 22 years, asthma 2 years	Hay fever and asthma	Vaccines, diets, etc.	1	No recurrence
2	6/20/34	7	4 years	Hay fever, vernal conjunctivitis	Medical	1	No recurrence
3	6/25/34	37	7 years	Hay fever	Vaccines three seasons	1	No recurrence
4	7/9/34	20	18 years	Hay fever	Alcohol injection	1	No recurrence
5	7/9/34	25	5 years	Hay fever		1	No recurrence
6	7/10/34	42	15 years	Hay fever, chronic pansinusitis	Vaccines, intranasal sinus op., polyps often removed	1	No recurrence, sinuses clean, polyp remnants disappear
7	7/17/34	30	5 years	Hay fever		1	No recurrence
8	7/17/34	34	3 years	Hay fever		1	No recurrence
9	7/21/34	46	14 years	Hay fever	Vaccines	1	No recurrence
10	8/7/34	24	6 years	Perennial hay fever		1	No recurrence
11	8/8/34	60	8 years	Asthma	Medical	1	Recurrence
12	7/26/34	19	1 year	Hay fever		1	No recurrence
13	8/3/34	58	20 years	Hyperesthetic rhinitis	Much medical	1	No recurrence
14	8/18/34	54	20 years	Hay fever		1	No recurrence
15	8/22/34	51	15 years	Asthma		1	No recurrence
16	8/24/34	13	6 years	Hay fever, asthma	Vaccines	1	No recurrence
17	8/25/34	12	9 years	Asthma		2	Asthma returned
18	9/7/34	26	12 years	Hay fever	Vaccines	1	No recurrence
19	9/20/34	15	5 years	Hay fever	Vaccines	1	No recurrence
20	9/22/34	52	10 years	Hay fever, asthma, urticaria	Vaccines	1	No recurrence
21	9/25/34	35	1 year	Asthma		1	No recurrence
22	9/27/34	54	20 years	Asthma	Vaccines, diets	1	No report on this case
23	9/28/34	37	15 years	Asthma	Vaccines, diets	1	No recurrence
24	10/2/34	22	1 year	Hay fever		1	No recurrence
25	10/3/34	40	2 years	Hay fever		1	No recurrence
26	10/2/34	60	25 years	Hay fever	Vaccines	1	No report on this case
27	10/5/34	10	Since infancy	Asthma	Vaccines and diets	1	Asthma returned
28	11/8/34	18	Since childhood	Hay fever		1	No recurrence

couraging, as in Cases 11, 18 and 27; however, Cases 15 and 23 have had no recurrence of their asthma after intranasal ionization. In Case 23 there was cutaneous reaction to cotton-seed meal and cotton-seed products, but leaving them out of the diet, along with any other measures we used, did not prevent the recurrence of asthma, while ionization did.

When a nasal septum resection is needed so badly that it is impossible to reach all parts of the nostril and nasopharynx, as is required in ionization, there will be no success until after a submucous resection.

We have followed Warwick technique in our work. Table 1 presents a brief summary of patients who have been treated by us.

T. W. Patterson Building.

BILATERAL EMPYEMA—CLOSED DRAINAGE WITH PEZZER CATHETER

By Elmer M. Bingham, M. D.
Riverside

THE treatment of empyema by closed drainage is the most satisfactory method in a majority of cases. Where good drainage can be accomplished by thoracotomy without resection of ribs, there is the distinct advantage of lessened surgical procedure and more rapid recovery. Where both pleural cavities must be drained, closed drainage is desirable, and is nicely accomplished by the procedure here described.

After incising the skin over the desired intercostal space, an ordinary Day suprapubic bladder punch is inserted into the pleural cavity and the trochar removed. A No. 22 Pezzer catheter, snugly fitting the cannula, is introduced with a uterine sound and the cannula withdrawn. Gentle traction gives an air-tight closure. The catheter is large enough, so that it is not easily compressed. Under ordinary circumstances, it is self-retaining. Connected with the usual siphon, it gives very satisfactory drainage.

REPORT OF CASE

A. B., a white male of seventy-two, was admitted to the Riverside County Hospital on May 5, 1934. His history indicated cardiac embarrassment since February, much worse three weeks prior to admission. He complained of dyspnea, productive cough, and swelling of his feet. On admission, temperature was 101 degrees; pulse rate, 100. Examination showed a fibrillating heart, moist râles at the bases of the lungs, and pretibial edema. Laboratory: hemoglobin, 88 per cent; white blood cells, 6,600; urine, a trace of albumen; blood Wassermann, negative.

The patient improved under digitalis and rest, temperature subsiding. At the end of the second week he began having pleuritic pains in the right chest, temperature ranging to 103 degrees. On May 21 there was evidence of fluid in the right pleural cavity, and 250 cubic centimeters of greenish pus were removed by aspiration. This on culture showed pneumococcus. Three days later 1,800 cubic centimeters of similar pus were removed by thoracentesis. On May 30 he developed pains in the left chest, followed by signs of fluid. Bilateral thoracentesis on June 4 showed a bilateral empyema, with a culture of the same organism from the left pleural cavity. Both cavities were aspirated again a week later, more to relieve his dyspnea than with the expectation of curing him. His appetite was failing, and he was irrational at times. Temperature was rarely over 100 degrees, but his white blood count was 23,000, with 91 per cent polymorphonuclears.

On June 15 a Pezzer catheter was placed in the right side, using the technique described. Siphon drainage with Dakin's irrigations was entirely satisfactory, and the accumulation of pus in the left chest was removed by aspiration. On June 26 a left thoracotomy was done. The empyema cavities were satisfactorily draining, but the patient failed steadily in strength and coöperation, on some occasions getting up in bed and disconnecting the drainage tubes. He removed the left tube June 15, and it was not replaced. The right was taken out six days later, three days before he expired.

COMMENT

In 1933 Steinke[1] collected sixty-nine cases of bilateral empyema reported in the literature since 1910. The mortality varies greatly in the different series reviewed: Scanlon[2] reported a single case with recovery; Keyes[3] reviewed forty-one cases with eight deaths; Vaughan and Schnabel[4] reported seven cases, all fatal.

Bilateral empyema is comparatively rare in adults, extremely rare in the aged. No case over seventy years old has previously been reported in the literature available.

SUMMARY

1. A case of bilateral empyema in a man of seventy-two years is reported.

2. Closed drainage with a Pezzer catheter is suggested.

Riverside County Hospital.



Fig. 1



Fig. 2

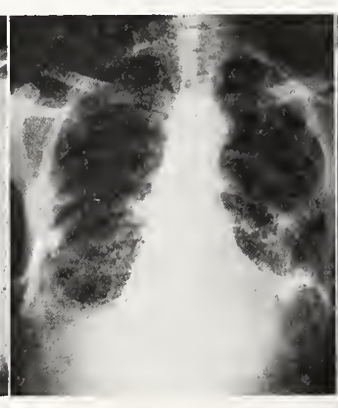


Fig. 3

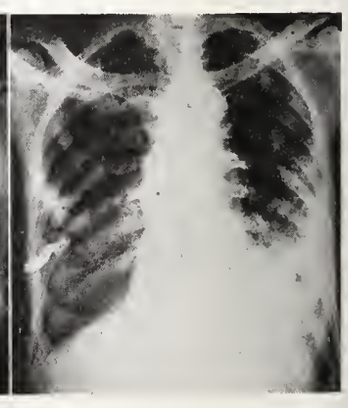


Fig. 4

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HEREDITARY DEFORMING CHONDRODYSPLASIA

REPORT OF CASES

By F. E. Blaisdell, Jr., M. D.
AND
E. H. Eiskamp, M. D.
Watsonville

IT would be entirely irrelevant at this time to offer any extensive treatise on hereditary deforming chondrodysplasia, as the facts already recorded, and recently reviewed, have been thorough and extensive. Dr. Kelley Hale [1] says that this disease is looked upon by all writers as a true hereditary affection, but he feels that more data should be presented in reporting cases, in order to rest this assumption upon a firmer foundation. The exact status of the disorder can be determined only by a larger series of cases.[2]

Our primary object is to report two cases: one an adult male who gives a history of a grandparent having the same affection, and a second case, his daughter, who presents an extensive and deforming involvement of most of her skeletal system. We are, therefore, able to demonstrate an apparent hereditary factor, the disease being transmitted from a grandfather through the unaffected mother of Case 1, and then directly to his daughter, Case 2. The value of this report lies essentially in the apparent demonstration of this fact. We are aware we have no direct evidence that the grandfather's "similar trouble" was the same disease. For this information we must, of necessity, rely upon the history as obtained from the patient and his mother. Fluoroscopic examination of the mother did not show any bone pathology.

REPORT OF CASES

Case 1.—Mr. B. P., age forty years, is a short, stocky man, who came under our care following the investigation of his daughter (Case 2). He has noticed bony growths about his knees and left hip as long as he can remember. These grew slowly larger until he was about twenty-one years of age; since then there has been little or no progression, and he has never been physically impaired by this condition.

His mother's father was afflicted with a similar bony condition. His mother is apparently normal, as checked by our fluoroscopic examination.

Physical examination reveals a large, palpable bony exostosis on the medial side of the distal end of each femur and a smaller one on the left iliac crest. There is a slight ulna flexion at each wrist.

Roentgenograms were taken of his knees, hip, wrist and ankle. These show typical bony excrescences on the femur, and also involving the tibia and fibula to a lesser degree, a good-sized nodule on the left iliac crest plus a few smaller lesions scattered about on the pelvic bones. The greater trochanters are involved to a slight extent. The wrist shows an ulna shortening and enlargement of the ulna tuberosity. Likewise, there is some involvement of the distal extremity of the tibia and fibula.

* * *

Case 2.—Miss T. P., age eighteen years, the daughter of Case No. 1, is a frail girl, with outward evidence of skeletal deformities. She comes with the complaint of periodic pain in her ankles, swelling and deformities of certain joints, and a susceptibility to colds.

This patient has always been sick since babyhood with colds and ear abscesses. Her father states that "lumps" were first noticed on her ankles when she was about three years old. Swellings also became noticeable on her wrists, hands, knees and feet, and grew slowly but progressively. She was examined at the University of California Medical Clinic in 1923, when a diagnosis of congenital exostoses was made. At this time the swelling of the left ankle was so large that the bony growth was removed surgically as well as another exostosis from the lateral condyle of the left femur. She has had periodic and variable pains in various joint regions, but her ankles have always given the most trouble.

Her height is 56½ inches and weight 89 pounds. There is an appreciable shortening of both upper and lower extremities.[3] The left auditory meatus is draining and the right drum appears thickened and fibrous. There is a slight thoracic scoliosis and the chest cage is irregular. Her hands and feet are small, the fingers and toes irregular as to size and shape, and there is a marked ulna flexion at both wrists. The right forearm is deformed. There is a slight tenderness to pressure from the fifth to seventh cervical vertebrae.

Urine, blood count, and Wassermann examinations were all normal. The sputum was negative for acid-fast bacilli.

Roentgenograms show typical changes throughout practically the entire skeleton. Both ankles show marked bony changes with deformities. There is a shortening of the fibula. The foot shows a moderate number of small exostoses involving the tarsal and metatarsal bones. At the knees there are extensive involvements of the tibia, fibula, and femur. Pathological changes about the wrists are marked with a deforming ulna shortening and its resultant ulna flexion. There are changes in the articular surfaces of both ulna and radius. The carpal and metacarpal bones present moderate changes. The elbows are also deformed. On the ribs are seen numerous small exostoses extending along the entire length in some cases. The shoulders show moderate bony changes involving the clavicles, acromion, and tuberosities. The pelvic pictures show numerous nob-like bony tumors on the iliac bones, and also some involvement of the trochanters.

COMMENT

Hereditary deforming chondrodysplasia has been known to have been transmitted by an unaffected mother, and affected mothers have had affected children by different husbands. Rarely it skips a generation in affected families. It remains to be proved that an unaffected male can transmit the disease.

In these lesions the bone cortex is thinned out and irregular islands of cartilage give the impression or appearance of cysts. The epiphyses escape tumor formation, but are small or misshaped. Spongy exostoses generally develop at the metaphyses of the long bones and at ends that show the greatest per cent of growth (lower end of the femur, both ends of the tibia, the proximal end of the fibula and humerus, and the distal end of the ulna and radius). This is exemplified in our cases.

SUMMARY

Two cases of hereditary deforming chondrodysplasia are presented, that of a male and then his daughter. The mother of the male is free from the disease, but the father is said to have had a similar disease. We therefore have an apparent transmission of the disease from a male on through an unaffected female to her son, and then on to his daughter.

Lettunich Building.

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ABDOMINOSCROTAL HYDROCELE

HOUR-GLASS HYDROCELE

By H. H. Parsons, M. D.
Grass Valley

ABDOMINOSCROTAL hydrocele is a rather rare condition and is, with some difficulty, differentiated from an inguinal hernia. In this condition, part of the sac is in the scrotum and part is in the abdomen; they communicate by means of a narrow neck which occupies the inguinal canal, thus giving the hour-glass effect. The intra-abdominal portion is usually the larger and is extraperitoneal. The contained fluid will flow from one sac to the other, depending on the position of the patient; and in so doing will often make a noise that may be mistaken for the gurgle of a hernia.

Richards [1] reported a case in 1908 and cited reports from thirty-one others, and Coleman [2] reported one of huge size, while Bickle,[3] Lakhoti,[4] Herrmann,[5] Curtis,[6] and Roller,[7] each report a case, and the latter discusses its supposed mechanism of production.

The one here reported occurred in a nineteen-year-old boy who was very tall, thin, and of rather effiminate appearance, and who complained that he had a hernia on the right side, an undescended testicle on the left, and of a small umbilical hernia.

He stated that these conditions had prevailed as long as he could remember.

Examination revealed that instead of a hernia he had an abdominoscrotal hydrocele, and it was only at operation that the true condition of the left testicle was determined. The right testicle was in the scrotum and was of normal size.

Operation was carried out February 7, 1933. The right inguinal canal was opened, as for a hernia operation, some of the fluid was removed from the hydrocele, and the intra-abdominal sac pulled down and dissected free, together with the scrotal and connecting portion, and removed except for the part adherent to the testicle which was allowed to remain with the testicle; closure, as in the Bassini operation. The intra-abdominal sac was about the size of an orange, the fluid content not being measured.

On starting the Torek procedure, the left cord was found leading into the left scrotum, where it terminated in a small mass of fatty tissue, evidently an aplastic testicle. The incision was closed and the operation terminated. Recovery was uneventful.

128 Neal Street.

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The Ear and Industrial Medicine.—The ear and industrial medicine was the subject of a discussion at the French otorhinolaryngologic congress in October, 1934. The first paper was by Caussé. Only five countries (Bulgaria, Czechoslovakia, Germany, Mexico and Russia) have placed deafness that is the result of the worker's occupation on an equal footing, so far as indemnity is concerned, with invalidity due to lead or mercury poisoning. There is no law of this kind in France.

Deafness from the standpoint of industrial medicine may be the result of injury to the skull, electricity, compressed air or intoxications and is also found in those engaged in occupations such as metallurgy and steel construction. The majority of cases of deafness in workers are due to traumatism of the head. Longitudinal fractures of the petrous portion of the sphenoid traverse the middle ear, while transverse fractures are more likely to involve the internal ear. The otologist is consulted most frequently in cases in which there has been a simple concussion of the brain without accompanying skull fracture. There is an absence of any relation between the degree of the injury and its sequelae. The patients in this first group are more likely to suffer from deafness than from vertigo.

Deafness due to electricity does not occur very often. Deafness may result in cases in which the current has not traversed the ear. In patients in this group the signs of deafness may appear quite a long time after the accident, thus making it difficult to determine the part the electrical shock has played. Accidents due to lightning belong in the same group. In divers or caisson workers the deafness is due to microscopic air emboli as shown by Paul Bert, the cochleovestibular apparatus being especially affected. One finds a sudden deafness or vertigo or both in most cases, but in some the symptoms do not appear immediately. Deafness or vertigo in such cases is not always permanent. Deafness due to intoxications is also not frequent, being seen most in the lead and next often in the mercury, arsenic or phosphorus industries. Deafness in those occupied in boiler or other riveting or railroad work is of increasing interest to otologists and is growing in proportion to the development of machinery in general. The otologist in making his report must always keep in mind the possibility of malingering; hence a thorough knowledge of the physiology of the internal ear is necessary.

In the discussion, Barraud of Lausanne emphasized the part played by modern mechanical devices and called attention to the deafness of soldiers in machine gun companies. Jacques of Nancy said that all cases of head or face injury should be examined as soon as possible after the accident.—Paris Letter.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

ENDOCRINE PREPARATIONS AND THEIR CLINICAL USEFULNESS

II*

LIVER EXTRACT AND SECRETIN

ARTHUR L. BLOOMFIELD, M. D. (Stanford University Hospital, San Francisco). — Liver as a therapeutic agent displays its most outstanding action in pernicious (Addisonian) anemia. Patients who eat large quantities of mammalian liver (calf, beef, hog), as first shown by Minot and Murphy, are relieved of the general symptoms of the disease and their blood counts rise to approximately normal levels. However, the disorder is not really cured; it is only kept under control; and even though the patient feels perfectly well, morphological changes of the red blood cells are still detectable, the achylia gastrica persists, and the central nervous system changes remain or may even progress. Experience in the past ten years indicates none the less that if people with pernicious anemia take liver faithfully they may live indefinitely at a reasonably high level of health. The term "pernicious anemia" has become a misnomer.

The beneficial effect of liver feeding is not yet clearly understood. In healthy people the "anti-anemic" substance seems to be elaborated in the stomach by interaction of normal gastric juice with certain (protein) food constituents, whence it is absorbed for storage in the liver. Evidence at present available indicates that this effective substance is either not formed or is not absorbed in the pernicious anemia patient, and it has in fact been shown to be absent from the livers of people dying of the disease. In the livers of pernicious anemia patients who died of extraneous causes *after liver therapy,* on the contrary, the effective substance has been demonstrated.

The principal objection to whole liver feeding is that patients tire of eating large quantities. Hence the effort to extract a potent liver fraction which can be taken in small bulk. These efforts have been successful, as every physician knows. We cannot go into the details of preparation here; suffice it to say that the so-called *fraction G* (of which approximately four grams represent the anti-anemic potency of 100 grams of fresh liver), is a *highly specific* product which is useful *only in pernicious anemia* and allied conditions, and *not in anemic states in general.* Fraction G, the pernicious anemia fraction, is now marketed by many pharmaceutical houses. It comes as a powder, which can be dissolved in warm water and taken as one would a "beef tea"; or it may be obtained in capsules. There are also liquid preparations. The doses vary; those of individual preparations are stated on the container by the manufacturer. In general, *large* doses (the extract of about 200 to 400 grams of fresh liver) must be given daily to produce a satisfactory remission; when this is achieved, a smaller maintenance dose sufficient to hold the blood count at a normal level must be worked out for the individual patient. If the dosage is adequate, the hemoglobin level after a latent period of a few days should rise ten or more per cent weekly.

For desperately ill patients, for those who seem to have difficulty in absorbing the effective substance per os, or for those who object to the taste, preparations which can be given intramuscularly are available. The advantage of these highly concentrated extracts is that they act somewhat more rapidly and certainly than the mouth preparations, and when remission has been accomplished a single injection of a few cubic centimeters, at intervals of a week to a month or more, may suffice for maintenance. The disadvantage is that of any hypodermic technique, together with the possibility of local soreness at the site of injection, and an occasional constitutional reaction. In practice we advise that every physician familiarize himself with one good intramuscular preparation, and with one to be taken by mouth rather than to vaguely prescribe a variety with none of which he is expert.

Fraction G has also been found to exercise a specific beneficial effect in sprue, a disease which is, of course, closely allied to pernicious anemia. The diarrhea abates, the blood count rises and constitutional symptoms disappear. The procedure is the same as with typical Addisonian anemia.

Aside from sprue and pernicious anemia, Fraction G has been reported to relieve the anemia associated with Diphyllobothrium (fish tapeworm) infestation, and occasionally to be helpful in ill-defined states of diarrhea associated with gastric anacidity.

Liver feeding has a definite but less dramatic blood building effect in certain types of "secondary" anemia. Whipple showed that dogs, maintained in a state of chronic blood depletion, regenerated hemoglobin much more rapidly if liver was added to the diet. So, too, in man, among the secondary anemias the best results are obtained in those due to chronic blood loss. Liver has been used for anemia due to cancer, Bright's disease, and various intoxications or infections, but with variable or slight effect.

* Part I of this symposium was printed in March issue of CALIFORNIA AND WESTERN MEDICINE, page 181.

A so-called secondary anemia liver extract is available. This is to be clearly distinguished from the pernicious anemia extract (Fraction G) discussed above. It is derived from an entirely different liver residue and *the two extracts cannot be used interchangeably.* The dosage of secondary anemia fraction is not accurately standardized; one usually gives two or more teaspoonfuls three times a day dissolved in hot water and sipped like a "beef tea." This material should be used together with full doses of iron, to which it acts as a supplement.

Liver exercises a dramatic curative effect in pellagra, provided the disease has not progressed to a hopeless degree. It is best given as whole liver by mouth—one-half pound daily. The exact effect of the various commercial liver extracts has not yet been determined.

Liver feeding, as well as injection of extract, has been useless in our hands in other diseases of blood such as leukemia, neutropenia, thrombopenia, and aplastic anemia.

Detailed specifications of the various liver preparations, which have been approved by the Council on Pharmacy and Therapy of the American Medical Association, are to be found in New and Non-Official Remedies. The physician is advised, as a rule, to make his selection from this list.

* * *

OTHER GLANDULAR EXTRACTS: SUCH AS POSTERIOR PITUITARY HORMONES AND THE MALE SEX HORMONE

RALPH ARTHUR REYNOLDS, M. D. (490 Post Street, San Francisco).—Posterior lobe extracts may be distinguished from most of the hormones in that they have been used clinically and experimentally as drugs, in addition to being used as replacement therapy in glandular deficiencies. The posterior lobe of the pituitary gland is made up of two distinct types of tissue, "pars intermedia" and "pars nervosa." The pars intermedia is thin, is poorly vascularized and is formed of densely packed basophil cells. It is believed by most workers that this portion contains the active principles referred to as posterior lobe hormones. The pars nervosa consists mainly of neuroglial elements and is highly vascular. While extracts of pars nervosa may yield "pituitrin," it is hardly probable that an entirely non-glandular tissue such as this should manufacture a secretion. The pars nervosa is much more likely to be the vehicle for transmission of the secretion formed by the intermedia into its blood vessels, or into the cerebro-spinal fluid of the third ventricle.

The term "pituitrin" is used as a convenient way of referring to crude extracts of the posterior lobe. Fühner, in 1913, isolated a pure crystalline basic substance which was placed upon the market in the form of its sulphate, hypophysin. The two terms, "pituitrin" and "hypophysin" have been used interchangeably, but pituitrin is now the more accepted term. Crude extracts of the posterior lobe (pituitrin) contain:

1. *Vasopressin,* or *pitressin,* which is responsible for raising blood pressure and constricting capillaries;

2. *Oxytocin* or *pitocin,* which stimulates the uterus, but has a negligible effect on the blood pressure; and

3. *Antidiuretic hormone.* According to Kamm, the anti-diuretic action of pituitary extracts is due wholly to vasopressin, but many workers believe that the renal action may be due to yet a third principle.

4. *Histamin.* As is the case with all tissue extracts, crude posterior lobe extracts contain histamin, which can be removed by prolonged treatment with alcohol; but for purposes of this discussion, this product can be ignored.

Since the whole posterior lobe extract may be fractionated into two relatively pure preparations, one characterized by pressor activity and the other by oxytocic activity, it becomes a matter of interest to know which preparations are responsible for certain specific physiologic functions in the human body.

A. Antiduresis.

It has long been known that pituitrin exercises an antidiuretic effect in diabetes insipidus, which disease is usually regarded as resulting from a derangement in function of the posterior lobe. Melville and Halman, in quite recent work at McGill University, have obtained results in polyuric dogs which indicate that the antidiuretic effect is due to the pressor principle. The oxytocic constituent exerts no antidiuretic action which could not be attributed to contamination with pressor substance.

These investigators have also pointed out that, under certain conditions, the vaso-pressin substance will produce diuresis. It seems probable, however, that pitressin diuresis is observed only with preparations and doses which affect the circulation. While the diuretic action of posterior lobe extracts is probably due to vascular changes produced in the kidney, experimental work suggests that the antidiuretic action is not due to these vascular changes; the pressor fraction probably stimulates the epithelium of the renal tubules to absorb more water and thus to concentrate the urine. Pitressin, therefore, is being used more extensively at the present time in cases where it is desired to prevent excessive loss of water from the body tissues. It may be found useful in certain cases of nocturnal eneuresis, given either intranasally or by hypodermic injection.

B. Blood pressure.

Oliver and Schafer (1895) first reported that an extract of the pituitary gland raised the blood pressure. Soon afterward Howell determined that this effect was produced by extract from the posterior lobe alone. Injection of pituitrin will cause a contraction of arterioles, thereby producing a slow rise in blood pressure. There is usually a slowing of the heart rate, while the force of the heart

may be slightly increased. (There is little experimental evidence to suggest that pituitrin is of any value as a cardiac stimulant in man.) This effect on blood pressure in man is due to the pressor principle in pituitrin, and is produced by constricting the arterioles. A second injection will often produce a fall in blood pressure. Probably the body develops an immunity to vaso-pressin, but it is thought by most investigators that this depressor substance is histamin.

C. Uterine contractions.

The posterior lobe of the pituitary is possibly one of the factors concerned in the onset of parturition. The uterus is not normally contractile during the first half of pregnancy: the spontaneous activity of the organ rises during the second half of pregnancy, and reaches its climax with the onset of labor. The corpora lutea may be responsible for the early quiescent stage; if the corpora lutea are made to persist longer than usual by injection of anterior pituitary extracts, it is found that the period of gestation is correspondingly prolonged. Oestrin, on the other hand, slightly stimulates the uterus and markedly increases its responsiveness to the oxytoxic fraction of the posterior lobe. Oxytocin, or pitocin, cannot produce abortion in pregnant women, except sometimes late in pregnancy when combined with other measures such as quinin injections and purgation. During labor, however, it powerfully increases the uterine contractions and helps to expel the foetus, and later the placenta. Due to the fact that pitocin contains the fraction from the posterior lobe that will produce strong uterine contractions (but does not, at the same time, affect the blood pressure), it is to be recommended over pituitrin. It is particularly useful in postpartum hemorrhage and in atonic uteri.

D. Other organs.

The smooth muscle of the bladder and of the small and large intestine are stimulated. It is probable that the pressor fraction is responsible for intestinal stimulation, although both the pressor and oxytocic constituents of the posterior lobe will produce defecation in the unanesthetized dog.

Black has recently reported a series of cases in which pitressin was used postoperatively in the prevention of distention. Pitressin has also been used successfully in combating the distention following peritonitis.

Postpituitary products stimulate smooth muscle widely throughout the body; this action is thought to be a direct one, and is independent of the integrity of the nerve supply of the tissues concerned.

E. Action on metabolism.

There are a certain number of observations which suggest that posterior lobe function is related to the processes of metabolism. It has not been definitely established that cases of adiposity resulting from pituitary damage are due to reduction of pituitary function or are due to accidental injury to adjacent structures such as the tuber cinereum. Furthermore, it is not known definitely whether or not the adiposity is due to a change in the water balance, or entirely to a fat deposition. It is known that the administration of pituitrin will cause a rapid and spectacular decline in weight in certain types of so-called pituitary obesity cases. It is my opinion that these cases represent water-balance upsets rather than real fat deposition.

Pituitrin will usually produce a transient rise of blood sugar, and occasionally a glycosuria. This is thought to be due to its antagonistic action to insulin. Pituitrin may be employed successfully in cases of insulin shock. It will cause a rapid rise of blood sugar and relieve convulsions and other symptoms of hypoglycemia.

MALE SEX HORMONE

For purposes of this discussion it is hardly necessary to enumerate the work of such investigators as Voronoff, Steinach and Stanley, since their experimental work has not been so much concerned with isolation of the male sex hormone as it has been with transplantation and reactivation of the testes. The most positive investigations in the direction of isolating the male sex hormone are those of Koch, Funk, McCullogh, McGee and others. Specific reactions produced by extracts presumably containing the male sex hormone have been based on the growth of a cock's comb and the restoration to normal of atrophic and functionless secondary genital organs in castrated animals. Extracts of bull's testicles that will prolong the life of spermatozoa in the epididymes of completely castrated guinea-pigs have been prepared. The male sex hormone has also been recovered in the urine of men, and a gonad-stimulating hormone has been recovered in the urine of pregnant and nonpregnant women.

Comparatively recent work has shown that injection of the male sex hormone in immature male rats produces a striking increase in the size of the seminal vesicles and the prostate gland. When combined with follutein, or with the urine of pregnancy, the change in these organs is still more striking. Thus far, the male sex hormone has not been definitely isolated and purified; but with constant improvement and extension of methods of assay for testicular hormone, it seems reasonable to assume that this important and elusive hormone will before long be isolated.

* * *

THE POSSIBILITY OF HORMONE IMBALANCE AS A CAUSE OF ESSENTIAL HYPERTENSION

Franklin R. Nuzum, M. D. (Santa Barbara Cottage Hospital, Santa Barbara).—Although the etiology of hypertension seems complex, definite advances have been made in our knowledge of this subject. Hypertension due to tumor of the adrenal glands is now definitely recognized. It may be paroxysmal in type and often reaches high levels. Hypertension that is associated with coarctation of the aorta is another distinct type. In

young individuals, particularly, this condition should be thought of. The increase in blood pressure that is associated with glomerular nephritis; that associated with the toxemia of pregnancy, and that frequently associated with obesity, may easily be classified.

There still remains that very large and important group generally known as "essential hypertension." The causes in this group are still problematical; and the theories offered in explanation are legion. One of the newer theories, and one which holds great interest because it seems logical, is that suggesting the possibility of a hormonal disturbance in this condition.

In 1903, Abelous and Bardier described a depressor substance in the human urine. Twenty years later Pribram and Herrnheiser demonstrated that this substance was nondialyzable. In 1928, Professor E. K. Frey, chief of the surgical clinic of the medical academy at Düsseldorf, and his associate, Heinrich Kraut, described in detail work with this substance. He found that at least 80 per cent of it was manufactured by the pancreas; that it was present in the blood stream in an inactive form, and that it was excreted in the urine in an active form. He called it a hormone (Kallikrein), and demonstrated that it was not elaborated by other endocrine glands. He and Dr. Albert H. Elliot have demonstrated that it neutralizes the effect of adrenalin; that it causes a drop in blood pressure, when injected into an experimental animal, and that, at the same time, it increases the amplitude of the heart beat.

Adrenalin is the most active pressor substance known. Professor Frey postulated that hypertension might result from a lessened amount of Kallikrein in the circulating blood stream and, therefore, a loss of balance between this substance (Kallikrein) and adrenalin. Theoretically, this is a most interesting explanation of essential hypertension.

My associate, Doctor Elliot, and I have demonstrated that the urines of persons with essential hypertension contain less amounts of Kallikrein than the urines of normal persons in the same age groups. It was found necessary to divide normal individuals into three groups: those between 20 and 40 years of age averaging, in a twelve-hour night sample of urine, a Kallikrein output of approximately 3,800 units; those between 40 and 60 years averaging 2,700 units; and those from 60 years on, averaging 1,700 units. In an equal number of individuals with essential hypertension, those between 20 and 40 years averaged 2,500 units; between 40 and 60 years, 1,600 units; and from 60 years on, 650 units.

It is, therefore, apparent that individuals with essential hypertension throw out in the urine very materially lessened amounts of this substance. A further step in proving or disproving this hypothesis, as to the cause of hypertension, would be the giving to patients who secrete a lowered amount of this material in the urine regular doses of Kallikrein, intramuscularly. We are following this procedure with a small group of individuals. We are not yet prepared to state what the outcome will be. Kallikrein may be obtained in this country from the Winthrop Chemical Company, under the trade name, Padutin. It should be given hypodermically, 1.0 cubic centimeter per dose, and from three to five times per week. No untoward side-reactions have resulted following this plan.

ASSEMBLY BILL No. 2397

INTRODUCED BY MR. HEISINGER

March 27, 1935

Referred to Committee on County Government

An act to add section 4041.16 to the Political Code, relating to the powers of the boards of supervisors.

The people of the State of California do enact as follows:

SECTION 1. Section 4041.16 is hereby added to the Political Code to read as follows:

4041.16. Under such limitations and restrictions as are prescribed by law, and in addition to jurisdiction and powers otherwise conferred, the boards of supervisors, in their respective counties, shall have the jurisdiction and powers to provide systems of hospital insurance available to the residents of their respective counties, and the board of supervisors of any county shall establish such a system upon the petition of twenty-five per cent of the registered voters of the county. Any system of hospital insurance established under this section shall provide for voluntary subscriptions thereto by those residents desiring to benefit therefrom. The supervisors shall establish subscription rates to be paid monthly or otherwise by the subscribers and shall prescribe the kind and extent of hospital services available upon paying the established rates therefor; and may provide for payments by subscribers over the minimum rates established for minimum services to entitle them to further or more special services, such as private or semiprivate rooms, drugs, additional or special nursing services, or such other things as the particular board of supervisors may find it expedient to furnish in return for such additional payments.

In any such system every subscriber thereto shall be entitled to the choice of his own doctor or physician and shall pay such doctor's or physician's fees for services rendered; but, in the cases of childbirth or of indigency of the subscriber, the board of supervisors shall provide medical care and treatment at county expense. Every board of supervisors establishing such a system shall prescribe rules and regulations for the conduct and administration thereof, including the termination of subscribers' rights for nonpayment of monthly or other subscriptions and the reinstatement of rights upon payment of delinquencies.

In any county where such system is established, the board of supervisors shall have power to rent or lease established hospitals or wings or portions thereof, and the total annual rental paid therefor by the county shall not exceed a sum equal to six per cent per annum of the actual appraisement of the property so rented or leased. Should two or more contiguous counties establish such systems of health insurance, such counties may jointly rent or lease hospital facilities for the convenience of their respective subscribers.

Should the funds received from payments by the subscribers under such system be insufficient to entirely defray the expenses in connection therewith, the board of supervisors may levy an additional tax upon all the property in the county, not to exceed per cent per annum, to help support the system; but any system shall be abolished which is found impractical because the total revenue from subscriptions and taxation is insufficient for its support.

SEC. 2. This act shall be known and may be cited and referred to as the Hospital Insurance Act of 1935.

The key to the world of the future and to the wise fraternity of all races lies in the liberation of the child from the bondage of others' error and sin; from disease and debility, from desertion and want, from ignorance and passion above all, that are visited on the helpless to the third and fourth generation. The heart of a child is friendly to all; like the baby of Della Robbia its limbs are bound, but its arms go out to its fellows. Its single claim is to be allowed to love; its one revenge to die if, for an hour, we neglect it.—Romain Rolland.

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Leaflet Regarding Rules of Publication.— California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

THIS YEAR'S ANNUAL SESSION AND PROGRAM—AT YOSEMITE NATIONAL PARK, MAY 13-16

This Issue is the Annual Program Number of the Official Journal.—The backbone of the outside cover of this issue of CALIFORNIA AND WESTERN MEDICINE carries the words "Program Number," a stimulating indication that the California Medical Association is again on the eve of holding an annual session. The announcements regarding the scientific programs of the Association's twelve sections, its general meetings, the hotel and transportation arrangements, are to be found on page 277. The reports of last year's work, as submitted by the officers and committees, are contained in the "Pre-Convention Bulletin," on page 304.

* * *

The Accommodations at Yosemite.—In its sixty-four years of existence, the California Medical Association has held two sessions in Yosemite National Park—in 1922 and 1925. Our last gathering there is yet remembered with especial pleasure by members who were in attendance, although at that time the hotel accommodations were not nearly so good as those of today; the Ahwahnee, for example, not yet being in existence, and the Yosemite Lodge and Camp Curry, with their auditoriums, dining rooms, and cottages, were of considerably lesser capacity and afforded no such ideal comfort as they now boast. The reservations made to date indicate that the 1935 annual convention will go down in our records as one of impressively large attendance.

* * *

Yosemite in May, One of Nature's Wonder Spots.—No citizen of the Golden State is a thoroughbred Californian until he has visited the Yosemite; yet in our Association are many members who have not yet beheld this great state and national playground. The month of May of this year, therefore, will be a better season than any, while the California Medical Association is again holding an annual session, to see the wonderland which nature has carved and spread out in our majestic High Sierra.

If the weather is pleasant at the time of the session, from Monday, May 13 to Thursday, May 16, inclusive—and all hope that it will be so—the floor of the Valley should be in the full glory of its wild flower blooms. Many members will no doubt prefer automobile travel to Yosemite, to that by railroad, since it affords an advantage when once in the Park, in going to different meeting-places and also in reaching the numerous scenic wonders, famous enough, as most are aware, to attract travelers from all parts of the world.

* * *

Important Work at This Year's Session.—In thus commenting on the unrivalled beauties of our prospective meeting place, we do not detract from, but rather add to the reasons why every member should make a very special effort to attend our 1935 reunion. The general assemblies, with their nationally-known guest speakers, the well-rounded scientific programs of the various sections, the important conferences on matters of medical economics, and other appealing activities, as well as both the scientific and commercial exhibits, have been so well arranged that all, combined with the fraternal good fellowship certain to be in evidence, will make the four days pass by altogether too fast. Members who cannot remain for the entire session should aim to be present for at least one or two days; the pleasures and profits experienced will more than repay all the temporary inconveniences involved in leaving patients. So once again, if you have not already done so, mark with blue pencil on your calendar the dates, May 13 to 16, and cogitate on ways and means that will enable you to be present at this year's annual session of the Association. Any sacrifice necessary will be worth the effort.

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

HEALTH INSURANCE RESOLUTIONS OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Special Session of the California Medical Association House of Delegates.—An abstract of the proceedings of the special session of the House of Delegates of the California Medical Association, held at Los Angeles on March 2 and 3, was printed in the March CALIFORNIA AND WESTERN MEDICINE on page 194, and it is to be hoped that most of the Association members have taken time to peruse the report. Of the resolutions introduced the one, more than any of the others, possibly fraught with a greater significance to the future of medicine in California, was the Ingber Resolution No. 2, printed in full on page 187 of the same March issue.

* * *

Ingber Resolution Should Be Read and Reread.—That resolution is worthy of being read not once, but many times. Its preambles, purposes and scope should have a familiar ring to every member of the California Medical Association; not only because, through its stipulations, legislation might be proposed that could greatly change conditions affecting much of the private practice of the majority of physicians in California, but also because it is important that, until final action is taken by the legislature and a new system instituted, the whole broad problem of sickness insurance should continue to be a subject of intensive study by every one of us. And this not from one, but from every point of view. The Committee of Six can act as the representative and spokesman of the five thousand members of the Association, but in new contingencies that may arise in the near future, that committee will be anxious to know what are the views and wishes of the members-at-large. So let us continue to study these important problems and from all aspects.

* * *

Proposed Legislation Is of Vital Importance to the Profession.—The legislation proposed is so vital to the standards and traditions of medical practice, and to the personal, economic interests of all physicians, that there is need of both earnest investigation and adequate comprehension of the entire subject, in order that scientific medicine in California shall continue to go forward; not with less, but with even greater impetus, toward the goal of achievement that seeks only the highest type of medical service to all population groups. At the same time, there must be full protection of that initiative which is so necessary in all medical progress, and of the economic rewards which will permit physicians to support themselves and their families in decently proper station, and assure those comforts and freedom from financial worries, which their conscientious services warrant, and which are so important if continued medical study and progress are to be made by each individual. Not so to demand and not that much to secure, would spell woe in our time, and for those who will follow us, in the days to come.

Stipulations of the Ingber Resolution Are Here Reprinted.—To again bring before the members of the Association the type of legislation which the California Medical Association House of Delegates on March 3 authorized the Committee of Six to secure, that portion of the Ingber resolution which outlines the nature of sickness insurance legislation likely to be acceptable to the members of the California Medical Association, is here reprinted:

Now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital.
2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system.
3. There shall be no provision for cash benefits.
4. The patient shall receive adequate treatment and his physician shall receive adequate compensation.
5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended or approved by the profession.

MORE CONCERNING PUBLIC HEALTH LEGISLATION

The Public Health Bills Now Before the California Legislature.—Each biennial legislative session places before the medical profession such a mass of prospective public health legislation that it is difficult to refrain from commenting on many of the suggested laws. In this, as in previous years, an appallingly long list of public health measures relating to public health and medical practice, have been submitted in the legislative halls at Sacramento, and for titles and numbers of several hundred of such bills the reader may consult page 229 of CALIFORNIA AND WESTERN MEDICINE for March. The Association's Committee on Public Policy and Legislation is still in the throes of its laborious task of trying to properly evaluate these various bills, and determine its attitude and course of action. In last month's issue of the JOURNAL (page 190), some of the more important measures proposed were briefly discussed, and comment at this time is limited to the bills noted below.

* * *

The Qualifying Certificate Act.—As was to be expected, the introduction of this measure (A. B. 1552), and its appearance in printed form, at once brought forth suggestions and proposed amendments. Some of these will probably be added to the bill in its passage through legislative committees; and discussion as to their desirability should make for a more rounded and perfect act. The California Medical Association Council, the Committee on Legislation and the Special Committee are carefully watching this qualifying certificate proposition, and may be counted on to safeguard the interests of healing art licensure, in so far as the bill relates to that vital matter. In the mean-

time, as previously remarked, members who have suggestions to offer should feel free to send them to the Special Committee.*

* * *

Antivivisection Bill.—The antivivisection measure that is introduced at practically every session of the legislature has finally made its appearance, with Charles J. Wagner† as its sponsor. In the legislature of two years ago, a bill for antivivisection was introduced by former Senator Fellom, whose very partisan advocacy led to sufficient reaction, in his own senatorial district, to make for his downfall when, last fall, he came up for reëlection in San Francisco. The Fellom bill was discussed on page 379 of the May, 1933, issue of CALIFORNIA AND WESTERN MEDICINE; and we are informed that the draft of this year's proposed legislation is along somewhat similar lines. The Hearst newspapers in San Francisco and Los Angeles are laying the foundations of their usual favorable publicity for this type of legislation, and interviews, with photographs of actresses, etc., designed to influence public opinion, have already appeared. The Ivy articles,‡ which were printed in CALIFORNIA AND WESTERN MEDICINE, should be of value in giving our legislators a true insight of the questions and principles at issue, and California Medical Association members who desire copies of these Ivy articles should send their requests to the Association secretary.

* * *

A. B. 2397: State Medicine via County Route —For Hospitalization, and also Partial Professional Service.—Assembly Bill 2397, introduced on March 27, 1935, by Mr. S. L. Heisinger of Fresno (who gives his occupation in the Assembly roster as that of a farmer), would add a new section to the political code. Indeed, if enacted, it would practically establish state medicine by permitting counties, or groups of counties, "to provide systems of hospital insurance available to the residents of their respective counties," whereby, "In any such system, every subscriber thereto shall be entitled to the choice of his own doctor or physician, and shall pay such doctor's or physician's fees for services rendered; but, in the cases of childbirth or of indigency of the subscriber, the board of supervisors shall provide medical care and treatment at county expense."

The bill further provides that if such moneys received from subscribers prove insufficient to pay for hospitalization and professional services, then the taxpayers are to make up the deficit. Maternity service is evidently to be free, without exception, to all citizens of a county. The county, in other words, is to pay for the medical care of indigents and of maternity patients, but there are no stipulations that members of attending staffs are to be compensated for professional services rendered. To cap the climax, to this astonishing measure is added an innocuous provision that a county hospitalization-professional service plan may be abolished if the income received from subscribers and tax funds be insufficient for its support!—leaving one to wonder as to when will the tax funds be insufficient?

The proposed bill, as printed in full on page 270, is not lengthy, and deserves a careful reading. Take time to give it such personal attention. The longer you think about its provisions, the more you will be impressed with both its scope and its dangers.

* * *

A Bill to Safeguard the Granting of Professional Degrees.—The League for the Maintenance of Professional Rights has been instrumental in introducing A. B. No. 1765 (Cronin), which measure is designed to prevent, in California, the incorporation of institutions and organizations not having sufficient material or scholastic resources, and their right to grant professional degrees. Such incorporations can easily become a racket.* The laxity now existent in California statutes, pertaining to this matter, is a sad reflection on so great a commonwealth. Whether the bill will go on to passage, is a question. In any event, the proposed law and its need will be called to the attention of the universities, colleges and educational groups of the State, in the hope of enlisting further study and full coöperation when the legislature meets two years hence. However, since no one knows what a jury or legislature will do, it is even possible that the wished-for A. B. 1765 may be rewarded with passage. The law is very much needed.

PROPOSAL TO LOWER STATE COMPENSATION FUND FEES

Newspaper Articles and Official Report Not in Line.—At the 231st meeting of the Council held on March 1, 1935, the subject of proposed reductions in professional fees by the State Compensation Fund, as indicated in newspaper interviews with officers of that bureau, was discussed at some length, and resolutions were adopted, which were to be forwarded to the Fund officers. The suggested necessity of reducing the fees seemed queer because of the optimistic outlook presented in an official communication, sent out under date of February 20, from which the following excerpts are taken:

"In a report submitted to T. A. Reardon, Director of the Department of Industrial Relations and chairman of the Industrial Accident Commission, by C. B. Day, manager of the State Compensation Insurance

* For report of the Special Committee in the "Pre-Convention Bulletin," see page 317 of this issue of CALIFORNIA AND WESTERN MEDICINE.

† In the "Assembly Weekly History," Assemblyman Charles J. Wagner is listed as business manager of the Butchers' Union, with home address at 1818 Cornell Drive, Alameda. The number of the bill is A. B. 2041.

‡ The Ivy articles were printed in the October, 1934, issue, page 247; and the November, 1934, issue, page 325.

* For instance, read the first item in the California State Board of Medical Examiners column, page 336, and which is here reprinted:

"Reports from the office of the Secretary of State relate that Percy Purviance, D. C., who, according to the records of the Board of Medical Examiners, has operated the Berkeley School of Chiropractic and the Golden Gate College of Chiropractic, recently added more schools to his list when, on December 28, 1934, he incorporated the Mount Vernon Chiropractic College, Corporation No. 160888, and on January 14, 1935, incorporated the International University of Naturopathy and Chiropractic, Corporation No. 161070, capital stock $100, divided into 100 shares of $1 each. The records indicate that both of these corporations state among their purposes is "to give diplomas." It is evident that legislation passed in 1927, 1929, and 1931, attempting to regulate the incorporation and operation of degree-conferring institutions, which have neither physical equipment nor financial responsibility, has proved ineffective."

Fund, material gains are noted over the previous year (by the California State Compensation Fund).

"The premium income for 1934 totaled $5,608,792, an increase of $1,384,981, or 33 per cent, over 1933. Approximately twenty-six thousand employers patronize the Fund, or one-third of the insured payroll in the State. While the new business written increased materially. . . .

"The financial position of the Fund is now the best in its history. . . .

"The Fund's surplus increased $24,400, during the year, to a total of $1,965,346.

"This surplus and the adequate reserves invested in high-grade securities are evidence of the Fund's financial ability to meet all its obligations to policyholders and their employees, and to meet any contingency which may arise."

* * *

Resolution of the Industrial Section of the Los Angeles County Medical Association.—The Sections on Industrial Medicine of the San Francisco, Alameda and Los Angeles County Medical Associations sent resolutions of protest to the Fund officers, the Los Angeles resolutions reading as follows:

WHEREAS, We are advised that the State Compensation Insurance Fund has applied for a hearing before the Industrial Accident Commission for a reduction ranging from 25 to 50 per cent in the fee schedules for professional services rendered industrial accident patients; and

WHEREAS, The fee schedule for professional services to industrial patients is already much below that for similar work in private practice; being in fact so low that the fees granted are really less than they should be when all the responsibilities of the Fund, the workers, and the physicians are honestly taken into account; and

WHEREAS, For the Fund to lower its fee schedule still more would work a gross injustice to physicians (who as a class and as individuals are also workers, and who as a class give gratuitous service, which if translated into money values far exceeds that given by any other group, to the care of indigent citizens); and

WHEREAS, Actuarial records increasingly show, with the passing of years, that the best investment for the economic administration of an insurance carrier (and that includes the State Fund) is a personnel on the industrial panels of the ablest type of physicians, since through their services there are a lesser amount of temporary and permanent disabilities and, consequently, lesser costs to the insurance carriers; and

WHEREAS, The organized medical profession of the State as represented by the California Medical Association and its component county societies is opposed to such a reduction of fees, because so to do (1) would be to the injury of the working men and women of California who come under the jurisdiction of the Workmen's Compensation Act; (2) be to the detriment and disadvantage of the State Treasury and to the State Fund; and (3) would work a gross injustice upon the members of the very medical profession through the efficient services of whose members much of the past success of the State Compensation Insurance Fund has been due; now, therefore, be it

Resolved, That on behalf of the organized medical profession of California the Industrial Accident Section of the Los Angeles County Medical Association requests the Industrial Accident Commission to take no such action as has been proposed by the State Compensation Insurance Fund; and be it further

Resolved, That copies of these resolutions be sent to His Excellency, Governor Frank Merriam; to each of the Fund commissioners; to the manager of the Fund; to the California Medical Association and to each of its component county societies; and to the official publication of the California Medical Association.

Resolutions of the California Medical Association's Council.—The Council of the California Medical Association also passed resolutions; and because they cite and emphasize some of the abuses now existing, they are here reprinted in full:

WHEREAS, It has come to the attention of the California Medical Association that effort is being made by the State Compensation Insurance Fund and other insurance companies writing Workmen's Compensation insurance to reduce fees for industrial accident surgery; and

WHEREAS, In the past the fee schedule of the Industrial Accident Commission has not been adhered to in all instances; and

WHEREAS, The Industrial Accident fee schedule provides such moderate charges for professional services rendered in accident cases, that to reduce the same would result in great injustice not only to the medical profession, but particularly to citizens suffering from industrial injuries (in that such excessively low fees would undoubtedly lead to inadequate service, thus making for longer temporary disability, as well as more and greater permanent disabilities among injured workmen, with resultant money loss to insurance companies that would be in excess of the sum saved through lower fee table for professional services); and

WHEREAS, Certain physicians and surgeons, some being members of the California Medical Association, have been guilty of cutting fees below the official fee schedule, and/or have made a practice of underbidding for industrial accident work other members of our profession and/or have been guilty of rebating to the insurance companies; now, therefore, be it

Resolved, By the Council of the California Medical Association:

1. That the Council make strong protest to the Industrial Accident Commission against reduction of fees;
2. That the members of the medical profession be advised of their responsibility in the matter;
3. That the fee schedule be reviewed and adequate arguments for adherence thereto be emphasized; and
4. That the Industrial Accident Commission be requested to adhere to the fee schedule itself in all its departments, and to require recognition of the schedule of insurance companies; and be it further

Resolved, That investigation of and methods for correction of these abuses be at once undertaken by the California Medical Association Committee on Industrial Accident Practice, with the least possible delay.

SICKNESS SURVEY OF THE UTAH STATE MEDICAL ASSOCIATION

Utah State Medical Association Makes a Preliminary Report.—A preliminary report, to be used in a survey of medical services and facilities of the State of Utah, was recently made by its Committee on Medical Economics, Public Policy and Relations. This prefatory communication consists of some thirty-four pages of typewritten facts and comments which should be of special interest to California physicians; particularly so, since the California Medical Association is making its own somewhat extensive survey of sickness incidence.

In its introduction the Utah report calls attention to the fact that, because of the peculiar geographic and economic conditions existing in that state, it would be quite possible to gather factual information considerably different from what may be found in other sections of the United States.

* * *

Geographic and Population Features of Utah which Influence Medical Practice.—For those who are not acquainted with the geographic areas in-

volved, it may be stated that the State of Utah covers some 82,184 square miles; that it is one and one-half times as large as Michigan; that its geographic domain is larger than that of the states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey and Maryland, grouped together. On the other hand, it had in 1930 a population of only 507,847, which is only about 10 per cent of that of Michigan and about 3.6 per cent of that of the entire group of eastern states above noted. The number of persons per square mile in Utah is 6.2. In recent years the older-age groups have begun to predominate, because of a lesser amount of immigration into Utah, and because of a dropping birth rate. About 52 per cent of the populace is urban, about 48 per cent rural, the latter being subdivided into 44 per cent of farm and 56 per cent of nonfarm populace. The size of an average Utah family is a little less than four persons.

* * *

Proportion of Physicians to Population in Utah, California, and Other States.—The following table gives, in the first column, the population density per square mile; in the second, the number of square miles per physician; and in the third, the number of persons per physician.

PHYSICIANS IN RELATION TO AREA AND POPULATION OF STATES (1931)

	Population Density Per Sq. Mile	Square Miles Per Physician	Population Per Physician
Utah	6.2	168	1,040
California	36.5	26.0	562
Massachusetts	528.6	1.2	644
New York	264.1	2.0	599
Ohio	163.1	4.7	768

It will be noted from the above, therefore, that conditions of practice are quite different in Utah from those in the other states mentioned.

* * *

Population Incomes in Utah.—Under the heading of "Population Income" a fact or two are given from the Michigan survey which are worthy of thought. The Michigan report states: "While it is customary to think of . . . food, clothing, and shelter . . . as the basic human needs, . . . the position of medical care in the scheme of living is anomalous. Even though it occurs as a basic need, its cost must be met *after* the other daily basic needs have been provided."

Some interesting information, also, concerning gross and net incomes is given, the tables showing that 15 per cent of the persons in Utah who sent in state tax reports received 44 per cent of the income, while 6 per cent received 26 per cent. In Michigan 92 per cent of its populace received only 8 per cent of the income. And the compilers of the Utah report make the following interesting comment on population incomes there:

"At the present time (December, 1934) between 20 and 25 per cent of the population are on relief and unable to pay anything for medical care, whether this is provided on a fee basis or on a periodic payment plan. In some counties this group approaches 50 per cent of the population. Theoretically, provision of medical care to this group is a responsibility of government units; practically, it is a burden principally assumed by the medical profession."

Medical Services Donated by Utah Physicians.—Other tables given in the report are in line with similar factual information to be gleaned from the reports of the National Committee on the Costs of Medical Care, and the surveys made by state and county medical societies throughout the Union.

One paragraph, for example, dealing with the amount of charity work constantly being done, and donated by the medical profession, may be quoted in its entirety:

"Michael Davis, who is certainly not an apologist for the medical profession, writing in the Bulletin of the Milbank Memorial Fund, states that *physicians donate each year in services a sum equal to all charity donations of the whole public to organized agencies (twenty-two), besides contributing themselves to those same agencies.* Physicians of the State of Utah, in replying to the questionnaire, estimated that in the first three months of 1934, 29 per cent of all their work was charity to those unable to pay. (This does not include uncollected charges, nor donations of service through reduced fees). In several counties, this reached as high as 75 per cent and 85 per cent of all work done. Certain it is, on incomplete returns, that at least six counties made no appropriation for medical services to the indigent sick in 1934, and five of these made no such appropriation in 1929 before the depression. In all the other counties, only a small part, if any, of the costs of medical services to indigents was borne by public funds. (Many counties likewise make no appropriation for hospitalization of the indigent sick.) Yet the state law makes it mandatory for counties to provide medical and hospital care."

* * *

Other Features of the Preliminary Report.—Various plans on caring for low-bracket income citizens are discussed in the report. The survey staff of the Committee of Five of the California Medical Association discussed such remedial measures in its preliminary report, excerpts from which were printed on page 160 of the March issue of California and Western Medicine.

Our colleagues in Utah are to be congratulated on the excellent manner in which their preliminary report has been compiled; for it gives valuable information to those members of the profession who at this very time are making a special study of these sickness problems.

EDITORIAL COMMENT*

THE PHYSICIAN AND CHARITY†

The great ideal of the medical profession has always been to provide adequate service for the sick without regard to financial returns. Now, as in the past, this ideal prevails, in spite of the difficult times and the many abuses which have crept in.

All economists recognize that medical care ranks

* This department of California and Western Medicine presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

† This comment is here printed because it fits in with the statements made in California and Western Medicine's June, 1934, editorial on the Los Angeles County Hospital (page 427) and the July, 1934, editorial (page 50) on "An Injustice Which Should Be Remedied."

with food, shelter and clothing, as one of the absolute essentials of the citizenry. Provision is made, and rightly so, for supplying the last three—not by commandeering the grocer's, landlord's, or clothing merchant's stock in trade, but by assessing the fair cost of the same to public expense. For requisite medical care, however, the physician must submit to flagrant exploitation in the name of charity. His stock in trade—time and skill, the only assets he possesses—are openly confiscated, apparently without appreciation, certainly without acknowledgment of any kind.

A conspicuous example of the abuse referred to is the "charity hospital." Viewing the matter squarely from the standpoint of ordinary common sense, it is evident that the evils inherent in the charity hospital, as it is conducted today, are many and pernicious, involving not only injustice to the physician but actual insult to his intelligence. Institutions, palatial in design and equipment, are planned and erected *for the indigent.* Funds for the purpose are acquired by taxation in which the physician is mulcted in full measure. When completed they are manned by paid employees; likewise womanned. Not an employee, from the highest administrative official to the lowliest scullery maid, is expected to serve gratuitously—no one, in fact, *except the members of the attending staff!*

No parsimony ever seems to be manifested either in the number of paid operatives or in their rates of compensation. In fact, the big idea often seems to be to increase the size of the payroll rather than to recognize the real purpose for which the hospital exists—namely, to provide medical care for the sick. The red tape tangles resulting—but let that pass.

The attending staff is the very heart of the hospital, private and public. Patients do not seek institutional care for the primary purpose of sleeping, being fed, bathed, or otherwise coddled, but because they are ill and need medical attention. There are several more enjoyable pastimes than sojourning in a hospital bed. There would be no such thing as a hospital bed if the physician were eliminated. Yet—note this well—in the voluminous reports issuing from the business offices at stated intervals, the services of the attending staff are mentioned, if at all, only incidentally and in the most cursory terms. Never is the outstanding fact emphasized that those services are entirely gratuitous.

Why, it is even customary in certain charity hospitals to receive nonindigent patients and charge them for hospitalization. But, in such instances, the attending staffs are barred by law from collecting remuneration, even when it is ascertained that the rankest fraud was practiced by a patient in gaining admittance.

Just how and why this sorry state of affairs came about it is difficult to understand. The ideals and traditions of an altruistic profession are explanation enough of the inception of the evil. And a slavish adherence to precedent is some explanation, perhaps, of its persistence. But the time has arrived when the unhappy prospect looms that altruism may become merely another name for professional suicide.

One other point calls for mention. A contributory factor of no little significance, in furthering the imposition under which the whole profession suffers, grows out of the substitution of the name "General Hospital" for "Charity Hospital," which was quietly effected a few years ago as though by concerted agreement. Certain patients who could pay their way do not hesitate to seek charity in a "general hospital," and many, very many, obtain it. If the designation were, as it should be, *"charity hospital,"* self-respect might be expected, in some measure at least, to correct the abuse.

These are homely, not to say sordid comments, to set down in cold type. But we all know them to be true; and, however repugnant, the issues involved should be discussed now and again. Abuses are never corrected by ignoring them.

Oh yes! it is highly commendable to value the "approval of conscience," "fidelity to duty," etc. Still, it is well to bear in mind that such specious placebos do not pay office rent and gasoline bills.

947 West Eighth Street.

A. B. Cooke,
Los Angeles.

Physicians and the Optical Retail Code.—Demands are being made by the Optical Retail Trade Code Authority, in a letter addressed "To Oculists and Physicians Dispensing Ophthalmic Products," that the physician to whom it is addressed fill out a questionnaire relative to the nature and extent of the physician's optical business and pay assessments amounting to $3 for each employee in his service. It is asserted that "physicians selling glasses or servicing prescriptions" come fully within the scope of the Optical Retail Code. The assessment is for the support of the Optical Retail Trade Code Authority, a trade organization. The Optical Retail Trade Code Authority, by which these demands have been made, is organized under the National Industrial Recovery Act. The National Industrial Recovery Act does not purport in any way to regulate or control the practice of medicine. It specifically relates to "industry" and "trade" and to industrial and trade associations or groups. It relates only to transactions in or affecting interstate or foreign commerce. Under no provision of the act can a physician who confines his work to rendering professional medical services be subjected to any provision of the code or to any assessment under the code. A person who on his own account commercially buys and sells eyeglasses and spectacles and makes a commercial profit on the transaction is presumably within the purview of the Optical Retail Trade Code, even though he happens to be a physician. A physician, however, who buys and sells eyeglasses and spectacles only as the agent of patients for whom he prescribes them and without making any commercial profit on the transaction is not within the terms of that code. The fact that a physician charges for his professional services in prescribing and fitting glasses and spectacles does not alter the situation. The American Medical Association has protested against the attempt of the Optical Retail Trade Code Authority to bring physicians as such within the scope of the code that it administers. Pending the adjustment of these protests, physicians who are engaged in strictly professional work are advised to refrain from answering the questionnaire sent them by the Optical Retail Trade Code Authority and to refrain from paying the attempted assessment for the support of that code authority. The outcome of the protest will be promptly reported in *The Journal.—Jour. A. M. A.,* March 9, 1935.

GUEST SPEAKERS AT THE SIXTY-FOURTH ANNUAL SESSION CALIFORNIA MEDICAL ASSOCIATION

Speakers at General Meetings



JAMES S. McLESTER, M. D.
President-Elect, American Medical Association
Birmingham, Alabama



E. STARR JUDD, M. D.
Rochester, Minnesota



THOMAS P. SPRUNT, M. D.
Associate in Medicine, Johns Hopkins
University Medical School,
Baltimore, Maryland



GEORGE W. WHIPPLE, M. D.
Dean and Professor of Pathology, University
of Rochester School of Medicine,
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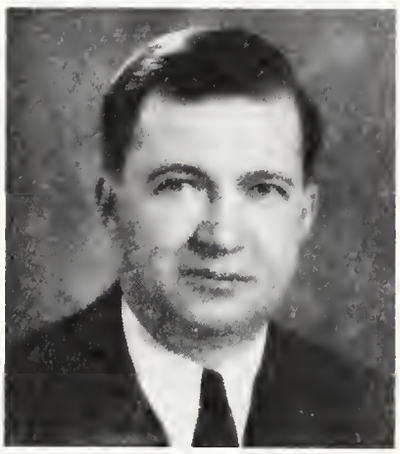
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PROGRAM

THE SIXTY-FOURTH ANNUAL SESSION *of the* CALIFORNIA MEDICAL ASSOCIATION

TO BE HELD AT

AHWAHNEE HOTEL, YOSEMITE NATIONAL PARK

MAY 13–16, 1935

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Delegates	Sessions	Alternates
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C. A. Dukes, Oakland	(1935-1936)	Edward N. Ewer, Oakland
Clarence G. Toland, Los Angeles	(1935-1936)	Edward M. Pallette, Los Angeles
Junius B. Harris, Sacramento	(1935-1936)	John H. Shephard, San Jose
William R. Molony, Sr., Los Angeles	(1935-1936)	John C. Ruddock, Los Angeles

* Resigned.

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The Secretary Ex officio
The Editor Ex officio

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F. M. Pottenger, Monrovia....1936
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Fletcher B. Taylor, Secretary of Section on General Medicine....Ex officio
William P. Kroger, Secretary of Section on General Surgery....Ex officio
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Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, who serve ex officio. The chairman of the committee is Dr. Charles A. Dukes, the secretary is Dr. Frederick C. Warnshuis. The director of the Department of Public Relations is Dr. Frederick C. Warnshuis.

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.
Daniel Crosby, Chairman, Committee on Hospitals, Dispensaries, Clinics.
Morton R. Gibbons, Chairman, Committee on Industrial Practice.
Harry H. Wilson, Chairman, Committee on Membership and Organization.
John H. Graves, Chairman, Committee on Medical Economics.
Junius B. Harris, Chairman, Committee on Public Policy and Legislation.
Charles A. Dukes, Chairman, Cancer Commission.
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Communications for the Public Relations Department should be addressed to the director, Dr. Frederick C. Warnshuis, Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Orville Meland (Secretary for Southern Section), Los Angeles....1935
A. Herman Zeiler, Los Angeles....1935
Gertrude Moore, Oakland....1935
Harold Brunn, San Francisco....1936
Henry J. Ullmann, Santa Barbara....1936
Clarence G. Toland, Los Angeles....1936
Charles A. Dukes (Chairman), Oakland....1937
Lyell C. Kinney (Vice-Chairman), San Diego....1937
Alson R. Kilgore (Secretary), San Francisco....1937

Communications for the Cancer Commission should be addressed to the secretary, A. R. Kilgore, M. D., Room 2004, 450 Sutter Street, San Francisco.

SPECIAL COMMITTEES

Committee on Arrangements—Yosemite Annual Session

Hartley G. Dewey (Chairman), Yosemite
Clarence G. Toland, Los Angeles
Lemuel P. Adams, Oakland
Robert A. Peers, Colfax
Eleanor Seymour, Los Angeles

Committee on Qualifying Certificate (Basic Science) Act

George H. Kress, General Chairman
Morton R. Gibbons, Chairman (for Bay Region)
Percy T. Magan, Chairman (for Southern California)
Junius B. Harris, Chairman (for Remainder of State)

REGISTRATION INFORMATION

Registration and Information.—The registration and information desk is located in the lobby, Ahwahnee Hotel. All persons attending the convention, whether members or not, are requested to register immediately on arrival. Beginning Monday, May 13, registration secretaries will be on duty daily from 9 a. m. until 5 p. m.

Programs and "Pre-Convention Bulletin."—The registration clerks will give to every member a copy of the program. The "Pre-Convention Bulletin" is printed in this issue of CALIFORNIA AND WESTERN MEDICINE. Delegates and alternates are especially requested to read the reports of officers and committees.

Guests and Visitors.—All guests and visitors are requested to register. All general meetings and scientific meetings are open to visitors and guests.

Badges.—Four kinds of badges will be issued by the registration bureau:

1. *Members.*—Only active, associate, retired or honorary members of the California Medical Association will be issued the usual membership badge.

2. *Guests.*—A guest badge will be issued to all fraternal delegates and visiting physicians who are attending the 1935 session.

3. *Delegates and Alternates.*—The usual official badge for each delegate and alternate is provided for this purpose, and will be issued only to one authorized to wear it.

4. *Officers.*—An official badge is provided for all officers and members of the Council.

Suggestions and Constructive Criticism.—The officers and committees have tried to do everything possible to make the session a success. Suggestions and constructive criticism calculated to make future sessions more useful will be welcomed by any of the officers. Complaints of whatever character should be promptly made to the registration desk, where they will receive attention.

Announcements

Please register on arrival and secure program and special announcements. Registration Bureau, Ahwahnee Hotel.

Delegates will please file credentials with committee at 7:30 p. m., Monday.

Secure tickets for President's Dinner at Registration Bureau. Dinner will be in Camp Curry dining room.

Please note meeting time of sections. Chairmen will be prompt in opening section meetings.

Commercial exhibitors cordially invite all members to visit their exhibits.

Park entrance fee $2 per car—good for entire year.

Past President's Breakfast, 7:30 a. m., Tuesday.

Council will meet at call of the chairman.

COMMERCIAL EXHIBITS

Adohr Milk Farms, 1801 South La Cienega Boulevard, Los Angeles. Booth No. 30.

Ayerst, McKenna & Harrison, Ltd., Rouses Point, New York. Booth No. 26.

Bilhuber-Knoll Corporation, 154 Ogden Avenue, Jersey City, New Jersey. Booth No. 20.

Certified Laboratory Products, Ltd., 1379 Folsom Street, San Francisco. Booth No. 5.

Cutter Laboratory, Berkeley. Booth No. 17.

Don Baxter, Inc., 1505 Gardena Avenue, Glendale. Booth No. 18.

H. G. Fischer & Company, 2323 Wabansia Avenue, Chicago, Illinois. Booth No. 7.

General Electric X-Ray Corporation, 450 Sutter Street, San Francisco. Booth No. 24.

Gerber Products Company, Fremont, Michigan. Booth No. 24.

Golden State Company, Ltd., 425 Battery Street, San Francisco. Booth No. 19.

Mead Johnson & Company, Evansville, Indiana. Booth No. 21.

Medical Protective Company, Wheaton, Illinois. Booth No. 6.

Pet Milk Sales Corporation, 24 California Street, San Francisco. Booth No. 29.

Philip Morris & Company, Ltd., 444 Madison Avenue, New York. Booth No. 28.

J. W. Stacey, Inc., 870 Market Street, San Francisco. Booth No. 16.

Stokely Brothers and Company, 1214 Fifty-seventh Avenue, Oakland. Booth No. 25.

Surgical Mechanical Research, 531 South Witmer Street, Los Angeles. Booth No. 31.

Western Surgical Supply Company, Ltd., 1926 Wilshire Boulevard, Los Angeles. Booths Nos. 22, 23, and 27.

MEMBERS OF HOUSE OF DELEGATES—32nd ANNUAL SESSION

Delegates Ex-Officio (21)

Clarence G. Toland, Los Angeles.....President
Robert A. Peers, Colfax.....President-Elect
Frederick C. Warnshuis, San Francisco.....
.....Secretary-Treasurer
Edward M. Pallette, Los Angeles.....
.....Speaker of the House of Delegates
John H. Graves, San Francisco.....
.....Vice-Speaker of the House of Delegates
George H. Kress, Los Angeles.....Editor
W. W. Roblee, Riverside (1935).....Councilor 1st District
Carl R. Howson, Los Angeles(1936)..Councilor 2nd District
Henry J. Ullmann, Santa Barbara (1937).....
.....Councilor 3rd District
*Fred R. De Lappe, Modesto (1935)....Councilor 4th District
Alfred L. Phillips, Santa Cruz (1936)..Councilor 5th District
Karl L. Schaupp, San Francisco (1937).....
.....Councilor 6th District
Oliver D. Hamlin, Oakland (1935).....Councilor 7th District
C. E. Schoff, Sacramento (1936).....Councilor 8th District
Henry S. Rogers, Petaluma (1937).....Councilor 9th District
Harry H. Wilson, Los Angeles (1935)....Councilor-at-Large
C. O. Tanner, San Diego (1936).....Councilor-at-Large
William H. Kiger, Los Angeles (1937)....Councilor-at-Large
Morton R. Gibbons, San Francisco (1935).....
.....Councilor-at-Large
T. Henshaw Kelly, San Francisco (1936).....
.....Councilor-at-Large
Junius B. Harris, Sacramento (1937)....Councilor-at-Large

Elected Delegates (117)

Alameda County (10)

Delegates	*Alternates*
Lemuel P. Adams	Dorothy M. Allen
Daniel Crosby	Chesley Bush
C. A. Dukes	W. W. Crane
Edward N. Ewer	John A. Dougherty
Robert A. Glenn	John N. Ewer
T. C. Lawson	William F. Holcomb
Frank R. Makinson	Eric Liljencrantz
Albert M. Meads	George McClure
George G. Reinle	Paul Michael
William H. Sargent	T. Eric Reynolds

Butte County (1)

N. T. Enloe — J. G. Hepplewhite

Contra Costa County (1)

U. S. Abbott — Kaho Daily

Fresno County (3)

G. W. Walker — C. M. Vanderburgh
Charles A. James — Edwin R. Scarboro
Thomas F. Madden — R. W. Dahlgren

Humboldt County (1)

Orris R. Myers — Wilson Stegeman

Imperial County (1)

L. C. House — Philip Hodgkin

Kern County (1)

L. A. Packard — F. J. Gundry

Kings County (1)

E. C. Bond — C. G. Newbecker

Lassen-Plumas County (1)

G. S. Martin — C. I. Burnett

Los Angeles County (37)

C. Max Anderson — Eliot Alden
Joseph T. Axline — L. A. Alesen
Wilford M. Briggs — John V. Barrow
Fred B. Clarke — Martin G. Carter
Jay J. Crane — Kenneth S. Davis
Dean E. Godwin — William Duffield
Leo J. Madsen — Walter L. Huggins
W. C. McKee — E. Eric Larson
William R. Molony, Sr. — Percy T. Magan
E. Earl Moody — W. S. Mortensen
John P. Nuttall — Thomas C. Myers
Oscar Reiss — William H. Olds
Philip H. Stephens — James F. Percy
Charles T. Sturgeon — John W. Shuman
Joseph K. Swindt — †Joseph R. Shuman
W. T. Webber — R. G. Taylor
Robert W. Wilcox — Packard Thurber
E. Vincent Askey — Walter F. Wessels
E. M. Burns — Walter A. Bayley
George Dock — Frank J. Breslin
Leland Ellis — E. L. Commons
Ralph B. Eusden — Egerton L. Crispin
Orrie E. Ghrist — William H. Daniel
W. V. Chalmers-Francis — Philip S. Doane
Lowell S. Goin — John B. Doyle
L. L. Henninger — John D. Gillis
George D. Maner — Bernard J. Hanley
Orville N. Meland — Louis Josephs
John W. Nevius — A. A. Kutzmann
Sterling N. Pierce — W. P. Kroger
John C. Ruddock — Samuel S. Mathews
Carl F. Rusche — W. A. Morrison
Raymond A. Sands — F. M. Pottenger
F. C. Swearingen — H. E. Schiffbauer
Arthur R. Timme — Willard J. Stone
E. Richmond Ware — A. H. Zeiler
E. T. Remmen — John W.Crossan

* Resigned.
† Deceased.

Marin County (1)

Delegates	*Alternates*
Carl W. Clark	Robert M. Furlong

Mendocino County (1)

R. A. Cushman

Merced County (1)

Hartley G. Dewey — Fred O. Lien

Monterey County (1)

Mast Wolfsohn — James McPharlin

Napa County (1)

Allan Kler McGrath — George I. Dawson

Orange County (3)

G. W. Olson — R. P. Yeagle
H. G. Huffman — M. W. Hollingsworth
D. R. Ball — F. H. Gobar

Placer County (1)

Lucas W. Empey — Mildred E. Thoren

Riverside County (2)

Thomas A. Card — Erwin P. Miller
G. W. Coon — N. K. Bear

Sacramento County (3)

George A. Briggs — H. M. Kanner
Oscar F. Johnson — Paul W. Christman
F. N. Scatena — Dave F. Dozier

San Benito County (1)

J. M. O'Donnell — R. L. Hull

San Bernardino County (3)

C. L. Emmons — A. L. Weber
G. S. Landon — C. A. Wylie
Ray Moose — A. E. Varden

San Diego County (5)

Hall G. Holder — Ross S. Carter
F. L. Macpherson — Andrew J. Thornton
S. J. McClendon — Clair L. Stealy
W. L. Garth — George D. Huff
Martha Welpton — James F. Churchill

San Francisco County (16)

Philip H. Arnot — Hamilton H. Anderson
Zera E. Bolin — Elbridge J. Best
Edwin L. Bruck — LeRoy Brooks
Loren R. Chandler — William A. Carroll
L. Henry Garland — Garnett Cheney
Philip K. Gilman — G. D. Delprat
Irving S. Ingber — George N. Hosford
Alson R. Kilgore — William J. Kerr
Mary Jones-Mentzer — Thomas H. McGavack
George Warren Pierce — Merrill C. Mensor
Langley Porter — Raymund J. Millzner
George K. Rhodes — James W. Morgan
Wilbur F. Swett — Robert S. Stone
I. W. Thorne — Edward B. Towne
Hans von Geldern — Morrell E. Vecki
Rodney A. Yoell — William C. Voorsanger

San Joaquin County (2)

Dewey R. Powell — Margaret H. Smyth
C. A. Broaddus — R. T. McGurk

San Luis Obispo County (1)

Jens W. Larsen — W. D. Butler

San Mateo County (1)

Hartzell H. Ray — William F. Knorp

Santa Barbara County (2)

Hugh F. Freidell — W. E. Johnson
Richard D. Evans — E. J. Lamb

Santa Clara County (4)

R. Stanley Kneeshaw — John H. Shephard
Russell V. Lee — S. B. Van Dalsem
C. Kelly Canelo — James P. Lovely
C. M. Burchfiel — George L. Barry

Santa Cruz County (1)

S. R. Tipton — M. D. McPherson

Shasta County (1)

M. D. Pratt — C. H. Law

Siskiyou County (1)

Charles C. Dickinson — Victor W. Hart

Solano County (1)

S. G. Bransford — Warren C. Jenney

Sonoma County (1)

F. O. Butler — Mark L. Lewis

Stanislaus County (1)

Hans Hartman — R. S. Hiatt

Tehama County (1)

J. L. Faulkner — E. E. Thompson

Tulare County (1)

Karl F. Weiss — Ray W. Rosson

Ventura County (1)

G. C. Coffey — William Felberbaum

Yolo-Colusa-Glenn County (1)

C. A. Poage — C. S. Roller

Yuba-Sutter County (1)

John A. Duncan — Neal M. Loomis

I—GENERAL MEETINGS

All General Meetings will be held in the Pavilion, Camp Curry

Monday, May 13, 10 A. M.

1. *Call to Order*—President C. G. Toland, M. D., Los Angeles.
2. *Announcements.*
3. *Greetings from American Medical Association*—President-elect J. S. McLester, M. D., Birmingham, Alabama.
4. *President's Address*—C. G. Toland, M. D., Los Angeles.
5. *Research in Medicine—Practical Applications*—E. Starr Judd, M. D., Rochester, Minn.

Tuesday, May 14, 11 A. M.

1. *Anemias, Experimental and Clinical*—George H. Whipple, M. D., University of Rochester School of Medicine, Rochester, New York.
2. *The Medicinal Treatment of Hepatic and Biliary Disorders*—Thomas P. Sprunt, M. D., Baltimore, Md.

Wednesday, May 15, 11 A. M.

Medico-Economic Problems:

1. *Profession's Economic Responsibility*—James S. McLester, M. D., Birmingham, Alabama.
2. *The Right to Regulate and the Reason for Regulation of Professions by the State, Methods Adopted for Regulation and the Attitude of Regulatory Bodies and the Courts with Relation Thereto*—Deputy Attorney-General Lionel Browne, San Francisco.
3. *Pertinent Facts Uncovered by the State Survey of Medical Services*—Paul A. Dodd, Director of California Medical Survey.
4. *What Is the Remedy?*—Harry H. Wilson, M. D., Secretary of the Committee of Five on Medical Survey.

II—HOUSE OF DELEGATES MEETINGS

32nd ANNUAL SESSION

Pavilion, Camp Curry

FIRST SESSION

May 13, 7:30 P. M.

Speaker, E. M. Pallette
Los Angeles

Vice-Speaker, J. M. Graves
San Francisco

Order of Business

1. Call to order.
2. Announcement by the Speaker on personnel of:
 (*a*) Reference Committee on Resolutions and on New and Miscellaneous Business: Philip Gilman, San Francisco, Chairman; F. N. Scatena, Sacramento; Lowell S. Goin, Los Angeles.
 (*b*) Reference Committee on Reports of Officers and of Standing Committees: John C. Ruddock, Los Angeles, Chairman; Langley Porter, San Francisco; W. W. Roblee, Riverside.
 (*c*) Credentials Committee: E. Eric Larson, Los Angeles, Chairman; Lemuel P. Adams, Oakland; S. J. McClendon, San Diego.
3. Report of Credentials Committee.
4. Roll Call.
5. Address of President Clarence G. Toland.
6. Report of the Council, T. Henshaw Kelly, Chairman.
7. Report of the Auditing Committee, Karl L. Schaupp, Chairman.
8. Report of the Secretary-Treasurer, Frederick C. Warnshuis.
9. Report of the Editor, George H. Kress.
10. Report of the General Counsel, Hartley F. Peart.
11. Report of the Chairman of the Committee on Public Relations, Charles A. Dukes.
12. Report of the Chairman of the Cancer Commission, Charles A. Dukes.
13. Report of The Trustees Of The California Medical Association, T. Henshaw Kelly, President.
14. Unfinished business.
 (*a*) Amendments to Constitution.*
15. New business. (Introduction of resolutions.)
16. Reading and adoption of minutes.
17. Adjournment.

* Editor's Note.—The proposed amendments are submitted with the Report of the Secretary (see page 308).

SECOND SESSION

May 15, 7:30 P. M.

Order of Business

1. Call to order.
2. Roll call.
3. Announcement of meeting place of 1936 annual session.
4. Election of:
 (*a*) President-Elect.
 (*b*) Speaker of the House of Delegates.
 (*c*) Vice-Speaker of House of Delegates.
 (*d*) Councilors.
 First District—Incumbent, W. W. Roblee, Riverside (1935).
 Fourth District—Incumbent, Fred R. DeLappe, Modesto (1935). Resigned.
 Seventh District—Incumbent, Oliver D. Hamlin, Oakland (1935).
 Councilors-at-Large—Incumbents:
 Harry H. Wilson, Los Angeles.
 Morton R. Gibbons, San Francisco.
 (*e*) Delegates and Alternates to American Medical Association for sessions 1936-1937.
 Incumbents of session 1935 are:

Delegates	Alternates
Elbridge Best San Francisco	Robert S. Stone San Francisco
Lyell C. Kinney San Diego	Harry H. Wilson Los Angeles
Fred B. Clarke Long Beach	A. J. Scott Los Angeles

5. Approval of members of standing committees elected by the Council.
6. Report of Reference Committee on Reports of Officers and Standing Committees.
7. Report of the Reference Committee on Resolutions and on New and Miscellaneous Business.
8. Presentation of President.
9. Presentation of President-Elect.
10. Reading and adoption of minutes.
11. Adjournment.

Table 1—Time and Place of Various Meetings and Entertainment

	Monday, May 13		Tuesday, May 14		Wednesday, May 15		Thursday, May 16	
	A. M.	P. M.	A. M.	P. M.	A. M.	P. M.	A. M.	P. M.
Pavillon Curry	General Meeting	Symposium Medicine, Surgery, Pathology Sections	Medicine and General Meeting	ENTERTAINMENT—OPEN AFTERNOON	Medicine and General Meeting		Medicine	
Dining Room 1 Curry			Surgery		Surgery	Symposium Surgery and Radiology	Surgery	Surgery
Dining Room 2 Curry			Gynecology and Obstetrics			Gynecology and Obstetrics		
Colonial Ahwahnee		Industrial Medicine and Surgery	Eye, Ear, Nose and Throat		Eye, Ear, Nose and Throat		Eye, Ear, Nose and Throat	
Ping-Pong Ahwahnee		Urology	Dermatology		Dermatology	Dermatology		
California Room Ahwahnee			Industrial Medicine and Surgery					
Writing Room Ahwahnee		Neuropsy-chiatry	Anesthesi-ology		Anesthesi-ology	Neuropsy-chiatry		
Solarium Ahwahnee		Pediatrics	Pathology		Pathology	Pediatrics	Pathology	
Tudor Lounge Ahwahnee		Radiology	Urology				Radiology	
Dining Room Curry				President's Dinner				
Room 330	Council							
Ahwahnee			Past President's Breakfast, 7:30		County Secretaries' Luncheon, 12:30 noon		Scientific Program and Section Officers' Luncheon, 12:30 noon	

III—SCIENTIFIC EXHIBITS

Lobby, Ahwahnee Hotel

1. *Pyodermatoses*—Nelson Paul Anderson, M. D., and Samuel Ayres, Jr., M. D., Los Angeles.

 The material will be entirely photographic and consists of clinical pictures of the pus-forming infections of the skin, including impetigo contagiosa, ecthyma, sycosis vulgaris, infectious eczematoid dermatitis, lupoid sycosis, dermatitis papillaris capillitii, recalcitrant pustular eruptions of the palms and soles, granuloma pyogenicum, and the rare blastomycosis-like lesions of the skin produced by pus-forming organisms.

2. *Exhibition of various substances of therapeutic value in the metabolic fields that have been obtained in pure or nearly pure form*—Alfred E. Koehler, M. D., Santa Barbara.

 Unsuccessful treatment with glandular and vitamin preparations so often is due to lack of potency. Standardization is greatly facilitated when the products have reached a high degree of purification. On the other hand, the danger of overdosage becomes an important factor when a high degree of potency has been reached. An example of overdosage can readily be demonstrated in the use of a preparation such as vitamin D. The high purification and chemical identification, such as vitamin C, has permitted simple chemical assay in food material and also in the urine excretion, permitting accurate balances to be carried out. The chemical test for vitamin C will be demonstrated.

3. *Wax models of stomachs of the Northern sea elephant, the California sea lion, the Harbor seal and the Galapagos fur seal, demonstrating gastric ulcers; also greatly enlarged wax models of the parasite Anisakis similis*—C. R. Schroeder, Veterinary Pathologist, Zoölogical Society of San Diego.

IV—ENTERTAINMENT

Monday

Tea, 4 p. m., Ahwahnee Hotel.

Fire Fall, 9 p. m.

Feeding the Bears, 9:30 p. m.

Tuesday

Auxiliary Tea—Honoring Mrs. Toland, 4 to 6 p. m., Ahwahnee Hotel.

President's Dinner, 7 p. m. Entertainment and dance.

Tuesday afternoon: No meetings scheduled. Opportunity for drive through Park, golf, tennis, etc.



MRS. PHILIP SCHUYLER DOANE
President



MRS. HARRY E. HENDERSON
Recording Secretary

V—WOMAN'S AUXILIARY

Sixth Annual Convention

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Yosemite National Park

Headquarters, The Ahwahnee—May 13 to 16, 1935

Mrs. Philip Schuyler Doane, President
Mrs. Frederick N. Scatena, Convention Chairman

Sunday, May 12

Arrival of delegates, members and guests, greeted by hostesses.

Afternoon tea in the Ahwahnee Lounge.

9:30 p.m.—Firefall ceremonies.

Monday, May 13

8:45 a.m.—Pre-Convention State Board meeting.

10:00 a.m.—Opening session of California Medical Association. All Auxiliary members are invited to attend.

9:00 a.m. to 1:00 p.m.—Registration in the lobby.

1:00 p.m.—Round-table luncheon at the Ahwahnee.

2:30 p.m.—Tour of the floor of the Valley, personally conducted by special guide.

9:00 p.m.—Reception and musicale in honor of Mrs. Clarence G. Toland.

Tuesday, May 14

9:00 a.m. to 4:00 p.m.—Registration in the lobby.

9:30 a.m.—Opening session of the sixth annual convention, Mrs. Doane presiding.

1:30 p.m.—Luncheon in honor of Mrs. Philip Schuyler Doane. Mrs. William H. Sargent will preside. Mrs. Harold Dewey Barnard, Chairman of Arrangements. The members of the State Advisory Council will be honor guests. Guest speaker, Dr. Frederick C. Warnshuis, secretary-treasurer of the California Medical Association and Speaker of the House of Delegates of the American Medical Association. Presentation of the Membership Trophy, Mrs. Doane.

4:00 p.m.—Afternoon tea in the Ahwahnee Lounge in honor of the past presidents of the Auxiliary.

7:00 p.m.—Dinner and dance, California Medical Association.

Wednesday, May 15

9:00 a.m. to 11:00 a.m.—Registration in the lobby.

9:30 a.m.—Second general business session and election of officers, Mrs. Doane presiding.

1:30 p.m.—Luncheon in honor of Mrs. Thomas J. Clark, president 1935-1936, at the Ahwahnee. Mrs. Philip Schuyler Doane will preside. Mrs. A. A. Alexander, Chairman of Arrangements. Guest speaker, Dr. James S. McLester, president-elect of the American Medical Association.

3:00 p.m.—Post-convention State Board meeting, Mrs. Thomas J. Clark presiding.

9:00 p.m.—Music and bridge party at the Ahwahnee. Mrs. John V. Barrow will be chairman of the evening.

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

CONVENTION COMMITTEES

Committee on Arrangements

Mrs. Frederick N. Scatena, Chairman

Mrs. J. Roy Jones
Mrs. Harry Kanner
Mrs. Orrin Cook
Mrs. Junius B. Harris
Mrs. George Briggs
Mrs. Bruce Barnes
Mrs. Paul H. Guttman

Transportation and Sightseeing

Mrs. N. N. Brown, Chairman

Mrs. Hobart Rogers
Mrs. Solomon N. Weil
Mrs. C. Kelly Canelo
Mrs. J. Frank Doughty
Mrs. F. W. Yocom

Information

Mrs. William A. Swim, Chairman

Mrs. A. Brockway
Mrs. John Crossan
Mrs. A. M. Hansen
Mrs. F. E. Detling
Mrs. R. S. Kneeshaw
Mrs. Mark Albert Glaser
Mrs. Charles E. Peters
Mrs. H. E. Schiffbauer
Mrs. H. D. Newton
Mrs. William H. Olds

Decorations and Flowers

Mrs. Bruce Barnes, Chairman

Mrs. Orrin Cook
Mrs. Paul Guttman
Mrs. George A. Briggs

Hostesses

Mrs. Andrew Mitchell Henderson, Chairman

Mrs. William W. Roblee
Mrs. John V. Barrow
Mrs. C. Kelly Canelo
Mrs. Robert T. Sutherland
Mrs. Manuel Fernandez
Mrs. Harry Huffman
Mrs. Homer H. Wolfe
Mrs. Hervey S. Faris
Mrs. John van Paing
Mrs. Emil C. Black
Mrs. N. N. Brown
Mrs. Chester J. Teass
Mrs. Charles Dukes
Mrs. Louis Henry Dyke
Mrs. Ruggles A. Cushman
Mrs. D. C. Cowles
Mrs. Arthur W. Walker
Mrs. Willard H. Newman
Mrs. Robert A. Peers
Mrs. Ursa S. Abbott
Mrs. Frederick F. Gundrum
Mrs. Thomas J. Clark
Mrs. Russell V. A. Lee
Mrs. Harold Dewey Barnard
Mrs. Edward M. Pallette
Mrs. H. H. Lissner
Mrs. Charles Sidney Stevens
Mrs. William H. Sargent
Mrs. Charles E. Howard
Mrs. Frank Edwin Coulter
Mrs. George G. Hunter
Mrs. Henry S. Rogers
Mrs. Philip Stephens
Mrs. John H. Shephard
Mrs. James Fulton Percy
Mrs. Dexter Ball
Mrs. A. Elmer Belt
Mrs. E. G. Raitt
Mrs. George G. Reinle
Mrs. George H. Sanderson
Mrs. G. I. Sellon
Mrs. A. A. Alexander
Mrs. H. O. Cleland
Mrs. Harry E. Henderson
Mrs. Frederick N. Scatena
Mrs. Horace Frederick Pierce
Mrs. Frank S. Baxter
Mrs. Robert E. Gleason
Mrs. F. J. Conzelmann
Mrs. John Norton Ewer
Mrs. Leroy B. Sherry
Mrs. Carl R. Howson
Mrs. Clifford A. Wright

Parliamentarian

Mrs. Frederick F. Gundrum

Credentials and Registration

Mrs. H. Waldo Spiers, Chairman

Mrs. Chester J. Teass
Mrs. Eliot Alden
Mrs. Glenn E. Myers
Mrs. H. Douglas Eaton
Mrs. George D. Maner
Mrs. Arnold M. Scholz
Mrs. A. H. Zeiler
Mrs. Harold P. Hare
Mrs. Alvin G. Foord
Mrs. W. D. Gilkey
Mrs. Harry F. Markolf

Publicity

Mrs. A. Elmer Belt, Chairman

Mrs. Harry E. Henderson
Mrs. Bert Thomas
Mrs. Frank P. Brendel
Mrs. A. M. Hansen
Mrs. C. M. Burchfiel
Mrs. Harold Trimble
Mrs. Robert E. Gleason
Mrs. K. H. Sutherland
Mrs. W. Remfrey Hunt
Mrs. Arthur J. Thornton

Ushers

Mrs. Franklin I. Ball, Chairman

Mrs. John L. Volz
Mrs. H. T. S. Bonesteel
Mrs. Peter H. Blong
Mrs. Hiram Curry
Mrs. G. W. Olson
Mrs. M. K. Tedstrom
Mrs. L. F. Whitacre

Pages

Mrs. E. Vincent Askey
Mrs. C. F. Browning

Properties

Mrs. Robert E. Gleason
Mrs. Edward Norton Ewer

Finance

Mrs. Frederick N. Scatena

MAY IN YOSEMITE

This year's session of the California Medical Association, as you undoubtedly already know, is to be held in Yosemite Valley, May 13 to 16.

This paper is written in an attempt to point out the possibilities of this beautiful spot during the month of May.

Of course, the major attraction of the Valley during this period is the full beauty of the waterfalls. With the snow of the high Sierra still in the process of melting, water in the falls is at its height, and they present perhaps the most typical phase of the Valley's changing moods.

Another beautiful boon which the spring brings to Yosemite and the surrounding mountains is the carpet of wild flowers. With the possible exception of the autumn, the Park is at its colorful best during this period.

According to the government weather man stationed here, the severe winter just past promises the finest flow of water over the falls in the history of the Valley. Precipitation (including the rain and the unusually high water content of the snow) reached a record high during the winter months.

All of Yosemite's larger falls—such as Yosemite, Bridal Veil, Vernal, and Nevada—made familiar to nearly everyone by the many published pictures, are of course the first that will catch your eye. But, besides these, there are dozens of others, less spectacular perhaps, but many of them higher and more beautiful than their larger brothers. These are falls that do not last through the entire year—some of them, in fact, last less than a month. But during May they, too, will be at their best.



A Sportsman's Paradise

Animal life in the Park is also at its height during this part of the year. The bears have appeared again after their winter hibernation, and the Park is alive with deer and smaller wild life. Rangers declare that spring brings more than 150 varieties of birds to Yosemite.

Yosemite Valley is actually only a small part of the huge area of Yosemite National Park. It contains only seven square miles out of a total area of 1,176. So, actually, no Yosemite trip can be complete without including hikes and saddle trips into the country back of the rim of the Valley.

Other diversions available during May include excellent fishing, golf, tennis, swimming, dancing, barbecues, or just plain leisurely loafing if that is your desire. Full information as to these and many other activities is obtainable anywhere in the Park. Or, if you wish to plan ahead for any particular trip, you can get full information by addressing the Yosemite Park and Curry Company, Yosemite.

Members of the Association may be interested to know that there is a fully equipped hospital in the Valley. The Lewis Memorial Hospital, named for W. B. Lewis, a former superintendent of the Park, is owned and operated, under a concession from the Government, by Dr. Hartley Dewey. Assisting him are Dr. Lee Weiss and from three to five nurses, depending upon the season of the year.

The hospital contains twelve beds and a nursery, and between five and six beds per day are occupied, on the average. It was built late in 1929 and contains modern, fully equipped laboratories. Doctor Dewey has announced that the hospital will be open for inspection during the session.



Mirror Lake, Yosemite Valley

VI—SECTION MEETINGS

Scientific Section Programs

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

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III.—Obstetrics and Gynecology (44-53) 292
IV.—Eye, Ear, Nose and Throat (55-66) 293
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Rules Regarding Papers and Discussions at the Annual State Session:

Upon recommendation of the Executive Committee, the following rules regarding papers have been adopted by the Council:

1. All papers read before a section of an annual session are the property of CALIFORNIA AND WESTERN MEDICINE.
2. The maximum time that may be consumed by any paper is fifteen minutes, provided that not to exceed ten minutes' latitude may be allowed invited guests at the discretion of the presiding chairman.
3. The maximum time permitted any individual to discuss a paper is four minutes. This also applies to the author in closing his discussion. No speaker may discuss more than once any one subject. The presiding officer of each section is expected to enforce these rules.
4. A copy of each and every paper presented at the state meeting must be in the hands of the chairman or secretary of the section, or in the hands of the general secretary before the paper is presented.

Each paper must be typewritten in double space. Single space and carbon copies are not acceptable.

5. All papers read at an annual session of the California Medical Association automatically become the property of the Association (By-Laws, Chapter VI, Section 4). The Committee on Publications of the official publication, CALIFORNIA AND WESTERN MEDICINE, decides whether or not the paper submitted is of such nature as to be published in full in CALIFORNIA AND WESTERN MEDICINE or in abstract form. (In case the latter procedure is followed, the expense of setting up the type for reprints may be borne by the Association.) It is also the ruling when any section has a larger number of papers on its program than can be covered in a two-day session, that not more than the average number of papers from such section shall be printed, unless for special reasons. Manuscripts not accepted for CALIFORNIA AND WESTERN MEDICINE will be returned to the authors, for submission to other medical journals, if so desired.
6. Articles are accepted for place on the program on condition that they are also contributed *solely* to CALIFORNIA AND WESTERN MEDICINE. Authors desiring to publish their papers elsewhere than in the journal must make written request to the editor. Papers submitted at meetings of this Association must not have been previously submitted or printed elsewhere.
7. No paper will be accepted by the General Program Committee nor by Section Program Committees unless accompanied by a synopsis of not to exceed fifty words.
8. Papers shall not be "read by title." Papers should be original typewritten copies, double spaced, and should be handed to the section secretary after having been read.
9. No member may present more than one paper at any annual session, provided that a member may be a collaborator on more than one paper, if these papers are presented by different authors.
10. Failure on the part of an author to present a paper precludes acceptance of future papers from such author for a period of two years, unless the author explains to the satisfaction of the Executive Committee his inability to fulfill his obligations.

Numbering of Section Papers

For convenience in reference, papers are numbered in serial sequence for the entire session, instead of a separate sequence for each section.

Business Meetings of Sections

Time of business meetings and elections of officers of sections will be scheduled on section blackboards by section secretaries, and through preliminary announcements by section chairmen.

Unless otherwise announced, the business meeting of each section and the election of officers will be held immediately after the reading of the second paper on the second day's section program.

I

GENERAL MEDICINE SECTION*

HILMAR O. KOEFOD, M. D., *Chairman*
1421 State Street, Santa Barbara

FLETCHER B. TAYLOR, M. D., *Secretary*
400 Twenty-Ninth Street, Oakland

First Meeting—Pavilion, Camp Curry
Monday, May 13, 2 p. m.

Clarence G. Toland, presiding

SYMPOSIUM ON DISORDERS OF THE LIVER

This will be a joint meeting of the following sections: Medicine, Surgery, Pathology and Bacteriology, and Obstetrics and Gynecology Sections.

1. *Regeneration of Hemoglobin and Plasma Proteins as Related to the Liver*—George H. Whipple, M. D., Dean and Professor of Pathology, University of Rochester School of Medicine, Rochester, New York. (By invitation.)
2. *Acute Disorders of the Liver*—Thomas P. Sprunt, M. D., Associate in Medicine, Johns Hopkins University Medical School, Baltimore, Maryland. (By invitation.)

 Acute disturbances associated with jaundice; those not associated with jaundice; acute diseases due to infection; acute disorders due to chemical poisons; the physician's responsibility in such cases; the recognition and treatment of acute hepatic disorders.
3. *Tests for Liver Function*—William J. Kerr, M. D., University of California Medical School, San Francisco.

 Certain tests for permeability of the liver and for determining the several functional activities of the liver are of value in clinical medicine. Their use will be discussed.
4. *Surgical Treatment of Diseases of the Bile Ducts*—Verne C. Hunt, M. D., 727 West Seventh Street, Los Angeles.

 A consideration of common and hepatic-duct stones, stricture of the common or hepatic ducts, primary malignant disease of these structures, and extrinsic obstructing lesions; also surgical indications and procedures in the treatment of lesions of the extrahepatic bile ducts.
5. *The Liver and Carbohydrate Metabolism*—Douglas R. Drury, M. D., Professor of Physiology, University of Southern California, Los Angeles. (By invitation.)

 The liver is the center for maintaining the proper blood sugar level; it stores extra glucose as glycogen, and releases this when needed. Besides this it has the remarkable capacity to convert into glucose a great variety of compounds such as glycerol, other carbohydrates, and many amino-acids.

 Deposition of fat is checked by deposition of glycogen, and vice versa. The presence of fat in the liver decreases its functional capacity.

 Discussion of symposium by Fred H. Kruse, M. D., San Francisco; Carl L. Schmidt, M. D., Berkeley; Theodore L. Althausen, M. D., San Francisco; and Alvin G. Foord, M. D., Pasadena.

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Second Meeting—Pavilion, Camp Curry
Tuesday, May 14, 8:30 a. m.

6. *The Treatment of Asthma and Other Allergic Phenomena by the Oral Administration of Adrenal Hormones*—F. M. Pottenger, M. D., and F. M. Pottenger, Jr., M. D., Monrovia.

 On the basis of allergic phenomena being associated with changes in physiologic equilibrium

* N. T. Ussher, M. D., 1421 State Street, Santa Barbara, and J. B. Graeser, M. D., 242 Moss Avenue, Oakland, are monitors for the General Medicine Section.

similar to those found in adrenal insufficiency, the cortical hormone was administered as an adjuvant to epinephrin. Salt and a special diet were also employed. Oral administration of adrenal substance was found satisfactory.

Discussion by James B. Graeser, M. D., Oakland.

7. *Agranulocytosis*—O. C. Railsback, M. D., Woodland Clinic, Woodland.

A summary of the salient features of the disease; its history and the pathological physiology; a discussion of the clinical aspect, emphasizing the diagnostic features, cause, differential diagnosis, and the relation of certain heavy metals and drugs, with special reference as to the rationale of the various forms of therapy.

Discussion by Stacy R. Mettier, M. D., San Francisco, and Madison J. Keeney, M. D., Los Angeles; O. H. Garrison, M. D., Oakland.

8. *The Adrenals—A Clinical and Pathological Study*—Ernest M. Hall, M. D., and Louisa Hemken, M. D., University of Southern California Medical School, Los Angeles.

Pathologic adrenal glands have been collected over a period of six years. The authors intend to present this material together with a short clinical history of each case. The material includes hemorrhage in the newborn (four cases) and adults (five cases); five cases of atrophy (postoperative death in three); Addison's disease due to tuberculosis (five cases); hypertrophy of the adrenals (one case); primary and secondary tumor growths (five cases).

Discussion by B. O. Raulston, M. D., Los Angeles, and Paul H. Guttman, M. D., Sacramento.

9. *Subtotal Bilateral Adrenalectomy in Essential Hypertension*—Neville T. Ussher, M. D., 1421 State Street, Santa Barbara, and P. A. Gray, M. D., 317 West Pueblo Street, Santa Barbara.

Detailed cardiorenal and metabolic studies in hypertension before and after subtotal bilateral adrenalectomy. Satisfactory and continued lowering of blood pressure following operation; also relief from previous incapacitating migraine attacks.

Discussion by Thomas Addis, M. D., San Francisco, and Howard W. Fleming, M. D., San Francisco.

10. *Heart Disease in Physicians*—Robert W. Langley, M. D., 1930 Wilshire Boulevard, Los Angeles.

A statistical report on the histories of one hundred and sixty-five physicians complaining of symptoms referable to the heart. Analysis of the various diagnoses is made and presented with the aid of charts.

Discussion by Eugene S. Kilgore, M. D., San Francisco, George Doek, M. D., Pasadena, and Willard J. Stone, M. D., Pasadena.

❧

Third Meeting—Pavilion, Camp Curry
Wednesday, May 15, 8:30 a. m.

SYMPOSIUM ON CLINICAL PROBLEMS OF PITUITARY FUNCTION

11. *The Relation of the Pituitary Gland to Diabetes and Other Aspects of Carbohydrate Metabolism*—I. L. Chaikoff, M. D., University of California Medical School, Berkeley. (By invitation.)

(1) Recent developments in the effect of hypophysectomy on insulin sensitivity; (2) the effect of hypophysectomy on the course of pancreatic diabetes and its therapeutic significance; (3) recent developments in the isolation of pituitary hormones regulating metabolism (diabetogenic hormone).

12. *Experience with the Anterior Pituitary Growth Factor*—E. Kost Shelton, M. D., 34 West Micheltorena Street, Santa Barbara.

A study of the clinical applications of the growth fraction of the adenophyophysis: Evaluation of its ability to produce growth and to combat hypophyseal insufficiency. Report of cases.

Discussion by Lyman A. Cavanaugh, M. D., Santa Barbara.

13. *Effect of Irradiation of Pituitary in Dysmenorrhea*—R. R. Newell, M. D., and A. V. Pettit, M. D., Stanford University School of Medicine, San Francisco.

One hundred and seventy-two patients suffering, some from dysmenorrhea, some from amenorrhea, and some from menopausal symptoms, were given x-ray treatment to the pituitary. During the same time an arbitrarily chosen series of sixty-six similar cases were exposed to an imitation of the same x-ray treatment, without actually receiving any x-ray. The subsequent symptomatology is compared for the two series.

14. *Gonadotropic Hormones*—C. F. Fluhmann, M. D., Stanford University Hospital, San Francisco.

Recent investigations have shown the existence in the blood or urine of men and women of substances which are capable of inducing specific changes in the ovaries or testes of experimental animals. Discussion of the possible significance of these factors, the conditions under which they appear, their relation to the anterior hypophysis, and their usage in clinical work.

15. *Pituitary-Adrenal Relationships*—Hans Lisser, M.D., University of California Medical School, San Francisco.

Both experimental and clinical evidence exists, highly suggestive of intimate interdependence between the anterior pituitary (adenohypophysis) and the adrenal cortex. A new anterior lobe hormone, adrenotropic, has been described and prepared in fairly pure state. Special consideration will be devoted to Cushing's disease, so-called pituitary basophilism, and to the adrenocortical syndrome, genitosurrenale. (Lantern slides.)

RECESS

Election of Officers and Business Meeting.

❧

Fourth Meeting—Pavilion, Camp Curry
Thursday, May 16, 8:30 a. m.

16. *The General Aspects of Cancer Susceptibility*—Ludwig A. Emge, M. D., 2000 Van Ness Avenue, San Francisco.

Theories of origin of malignant tumors will be discussed. The change from normal to cancer cell will be shown to depend upon tissue environment, and this tissue environment will be shown to depend upon hereditary factors. This is a lantern slide presentation of experimental material.

Discussion by Paul Michael, M. D., Oakland.

17. *The Uremia of Circulatory Failure*—A. A. Alexander, M. D., 1904 Franklin Street, Oakland.

The physics of kidney function will be discussed. Sudden or prolonged drop in blood pressure upsets normal renal activity. Though of frequent occurrence, this condition has only been recorded once in medical literature. Measures for recognition and treatment are discussed.

Discussion by John C. Ruddock, M. D., Los Angeles, and Thomas Addis, M. D., San Francisco.

18. *Hodgkin's Disease, Pulmonary Involvement*—Ernest H. Falconer, M. D., 384 Post Street, San Francisco, and Maurice Leonard, M. D., 639 Buena Vista Avenue, San Francisco.

This study is based on fifty-five cases of Hodgkin's disease; fifteen showed lesions of the lungs and pleura. Pathology, gross and microscopic, discussed. Types of x-ray manifestation shown and discussed. Treatment. Prognosis.

Discussion by Verne R. Mason, M. D., Los Angeles.

19. *Total Ablation of the Thyroid Gland for Congestive Heart Failure and Angina Pectoris*—J. H. Pettis, M. D., 1759 Fulton Street, Fresno, and E. D. Sorsky, M. D., Fresno County Hospital, Fresno.

A brief discussion of the present status of total ablation of the thyroid is presented. Several cases are discussed and certain stages in the surgical technique are illustrated by motion pictures.

Discussion by William Dock, M. D., San Francisco, and Richard D. Friedlander, M. D., San Francisco.

20. *Management of the Decompensated Heart*—R. Manning Clarke, M. D., 606 South Hill Street, Los Angeles.

Discussion of practical points in the use of well-known things such as rest, exercise, diet, position in bed, etc. Methods of administration and withdrawal of digitalis will be given special consideration. When to stop, and conditions demanding the indefinite continuance of treatment will be stressed; untoward signs in prognosis will be brought forward.

Discussion by William Leake, M. D., Los Angeles, and William H. Barrow, M. D., San Diego.

II

GENERAL SURGERY SECTION*

PHILIP K. GILMAN, M. D., *Chairman*
2000 Van Ness Avenue, San Francisco

WILLIAM P. KROGER, M. D., *Secretary*
902 Wilshire Medical Building
1930 Wilshire Boulevard, Los Angeles

H.GLENN BELL, M. D., *Assistant Secretary*
University of California Hospital
San Francisco

First Meeting—Dining Room, Camp Curry
Monday, May 13, 2 p. m.

SYMPOSIUM ON DISEASES OF THE LIVER

This will be a joint meeting of the following sections: Medicine, Surgery, Pathology and Bacteriology, Gynecology and Obstetrics Sections.

The program of this joint meeting is printed under the first meeting of the General Medicine Section. (See page 288.)

Second Meeting—Dining Room, Camp Curry
Tuesday, May 14, 8:30 a. m.

22. *Adenoma of the Parathyroid Glands Associated with Hyperparathyroidism*—Leon Goldman, M.D., University of California Hospital, San Francisco. (By invitation.)

This paper discusses the different phases of the concept of hyperparathyroidism and differentiates parathyroid adenoma, with its characteristic skeletal and metabolic changes, from other allied diseases of the bones or parathyroid body. Case reports are given of two patients of the same family who had hyperparathyroidism simulating giant cell tumor. Both patients were treated successfully by surgical removal of parathyroid adenomata.

Discussion by V. R. Abraham, M. D., Long Beach, and William C. Deamer, M. D., San Francisco.

23. *Toxic Adenoma of the Thyroid Gland with Normal or Lowered Basal Metabolic Rate*—H. H. Searls, M. D., University of California Hospital, San Francisco.

Consultants frequently permit the basal metabolic rate to influence strongly their impressions regarding disease of the thyroid gland.

In many patients this test does not parallel the clinical picture. The person with adenomatous goiter may show definite signs and symptoms of toxicity, but also exhibit evidences of hypothyroidism and have a low basal metabolic rate.

It is the purpose of this paper to present such a clinical picture, to point out the need for its recognition when encountered, and to attempt an explanation of the seeming paradox.

Discussion by Hans Lisser, M. D., San Francisco, Philip K. Gilman, M. D., San Francisco, and Benjamin Eager, M. D., San Diego.

24. *Head Injuries Complicated by Internal Hemorrhage*—D. H. Werden, M. D., Medico-Dental Building, San Diego.

This paper is based on thirty-five cases of head injury (all with concussion, sixteen with skull or brain injury, twenty-one with prolonged coma) which were complicated by associated obscure internal injuries resulting in internal hemorrhage. The paper emphasizes the clinical picture of head injury, and contrasts with this the picture presenting when there is, in addition, an internal injury. The latter is often the more serious injury, is often overlooked especially in the presence of coma and skull fracture, and results in death if unrecognized. Fifteen lantern slides shown in rapid succession illustrate the paper.

Discussion by Carl W. Rand, M. D., Los Angeles, and Edmund J. Morrissey, M. D., San Francisco.

25. *The Acute Traumatic State*—Edmund Butler, M. D., 490 Post Street, San Francisco.

Often the resultant injuries from automobile accidents and industrial accidents prove rapidly fatal. Occasionally life may be prolonged if the diagnosis may be made. The following conditions are to be discussed: head, chest, abdomen, extremities and trunk.

Discussion by Wallace Dodge, M. D., Los Angeles, and J. Homer Woolsey, M. D., Woodland.

RECESS

Election of Officers and Business Meeting.

Third Meeting—Dining Room, Camp Curry
Wednesday, May 15, 8:30 a. m.

26. *Acute Appendicitis in Children*—Conrad J. Baumgartner, M. D., 939 Pacific Mutual Building, Los Angeles.

A brief review of history and findings of fifty-five cases from the Children's Hospital is given. Managament stresses particularly the use of continuous siphonage by means of an indwelling nasal tube to the stomach, as well as continuous venoclysis of glucose solutions. (Illustrated.)

Discussion by William J. Norris, M. D., Los Angeles, and Harold K. Faber, M. D., San Francisco.

27. *Gas Bacillus Infection of the Abdominal Wall*—C. J. Berne, M. D., 1002 Pacific Mutual Building, Los Angeles.

The fifteen cases in the literature and five unreported cases are considered as a group. The nature of the infection, the special features of it when the abdominal wall is affected, and certain types of cases which result are described.

*H. Brodie Stephens, M. D., San Francisco, and John M. Schmoele, M. D., Los Angeles, are monitors for the General Surgical Section.

The mortality from the infection is discussed in relation to those cases in which the infection is limited to the wound, those in which spreading cellulitis occurs, and those in which peritonitis exists. Treatment is reviewed and suggestions made regarding it, under the general headings of chemical treatment, serological treatment and surgical treatment.

Discussion by Theodore C. Lawson, M. D., Oakland, and Philip J. Cunnane, M. D., Los Angeles.

28. *The Treatment of Varicose Ulcers and Veins*—John M. Schmoele, M. D., 1930 Wilshire Boulevard, Los Angeles.

Observations based on a series of eight hundred and twenty-six cases personally treated during the past five years, with follow-up record. Pathology, clinical and practicable aspects of diagnosis and treatment. Discussion of various methods. Selection of sclerosing agents. Discussion of Trendelenburg test. The necessity of intensive clinical study before treatment. Significance of end-results.

Discussion by Nelson J. Howard, M. D., San Francisco, and Hall G. Holder, M. D., San Diego.

29. *Hydrops of the Gall-Bladder*—Stanley H. Mentzer, M. D., 450 Sutter Street, San Francisco.

The paper is based upon a study of two hundred cases of hydrops of the gall-bladder, emphasizing the relative benignity of the clinical symptoms and signs in contrast to the severity of the prognosis when acute exacerbations develop. The data presented will stress a new conception of empyema of the gall-bladder and will rationalize the therapy of hydrops in the light of the facts uncovered.

Discussion by Charles T. Sturgeon, M. D., Los Angeles, and Joseph K. Swindt, M. D., Pomona.

30. *Perforation of Gall-Bladder with Generalized Choleperitoneum*—E. Eric Larson, M. D., 1930 Wilshire Boulevard, Los Angeles.

A study of the symptoms, diagnosis, and operative procedures in twelve patients having acute perforation of the gall-bladder with generalized choleperitoneum. Mortality of 50 per cent.

Discussion by Loren R. Chandler, M. D., San Francisco, and Harlan Shoemaker, M. D., Los Angeles.

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Fourth Meeting—Dining Room, Camp Curry
Wednesday, May 15, 2 p. m.

SYMPOSIUM ON DIAGNOSIS AND TREATMENT OF LESIONS OF THE STOMACH

This will be a joint meeting of the Sections on Radiology and General Surgery.

31. *Medical Aspects of Lesion of the Stomach, with Special Reference to Diagnosis and Operative Indications*—Arthur L. Bloomfield, M. D., Stanford University Medical School, San Francisco.

In order to evaluate intelligently the indications for operation in peptic ulcer it is necessary to have an understanding of the mode of production of symptoms. It has been believed by some that symptoms are due to direct irritation of the ulcer by acid; whereas others have thought that the symptoms are reflex in origin. These two theories are discussed critically, and from the results of these analyses certain conclusions as to indications for operation are deduced.

32. *Clinical Indications for Roentgenological Studies of the Stomach*—B. R. Kirklin, M. D., Mayo Clinic, Rochester, Minnesota. (By invitation.)

33. *Surgical Treatment of Lesions of Stomach and Duodenum*—E. Starr Judd, M. D., Mayo Clinic, Rochester, Minnesota. (By invitation.)

Discussion of symposium by Rea Smith, M.D., Los Angeles; Harold Brunn, M. D., San Francisco; Howard E. Ruggles, M. D., San Francisco; and Fred H. Krusc, M. D., San Francisco.

❦

Fifth Meeting—Dining Room, Camp Curry
Thursday, May 16, 8:30 a. m.

34. *Biopsy of Malignant Disease*—Otto H. Pflueger, M. D., 384 Post Street, San Francisco, and W. P. Stowe, M. D., St. Luke's Hospital, San Francisco.

The question of biopsy is of practical importance. This paper discusses the methods of obtaining biopsy specimens: (1) Incision into tumor. (2) Wide excision of tumor. (3) Needle puncture and aspiration. Indications and contraindications for each method are given. Slides of material obtained by aspiration are shown to demonstrate the value of this method of obtaining tissue specimens. (Lantern slides.)

Discussion by Emile F. Holman, M. D., San Francisco, and George D. Maner, M. D., Los Angeles.

35. *Perforated Peptic Ulcer*—Harold L. Thompson, M. D., 1930 Wilshire Boulevard, Los Angeles.

During the last twelve years, 535 perforated peptic ulcers have been observed at the Los Angeles County General Hospital. An evaluation of diagnostic signs and symptoms is based on a study of the clinical records of five hundred acute perforated peptic ulcers out of this series.

Discussion by George K. Rhodes, M. D., San Francisco, and Wayland A. Morrison, M. D., Los Angeles.

36. *Cancer of the Thyroid Gland*—F. B. Settle, M. D., 811 Professional Building, Long Beach.

Incidence. Relation to nodular goiter. Recent trend toward simplifying the classification of thyroid malignancies. Review of literature. Case reports. Treatment—surgery, irradiation, combination of surgery and irradiation. Preventive treatment—rationale of surgical removal of all nodular goiters.

Discussion by Robertson Ward, M. D., San Francisco, and William E. Costolow, M. D., Los Angeles.

37. *Radical Operation for Cancer of the Rectum, with Preservation of Sphincter Muscle*—Ernst Gehrels, M. D., 490 Post Street, San Francisco.

Through recent pathological investigation, especially by Westhues in Germany, additional light has been thrown on the spread of cancer of the rectum. There have also been very valuable new methods devised in extending the field of operation from below (Goetze), and new ideas of two-stage operation developed (Goepel). Based on these new conceptions, methods of procedure are discussed, making sphincter preservation possible in selected cases without sacrificing the aim of eradication of tumor nor increasing the mortality of the operation.

Discussion by Robert A. Scarborough, M. D., San Francisco, and Kenneth E. Smiley, M. D., Los Angeles.

38. *Cancer of the Rectum*—William H. Daniel, M. D., 1930 Wilshire Boulevard, Los Angeles.

A review of over two hundred cases will be presented. The following points, in addition to a plea for more frequent examinations, will be discussed: (1) The operability. (2) The grading of tumors. (3) The five most common surgical

procedures, and the indication for each. (Lantern slides and a motion picture.)

Discussion by William H. Kiger, M. D., Los Angeles, and M. S. Woolf, M. D., San Francisco.

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Sixth Meeting—Dining Room, Camp Curry
Thursday, May 16, 2 p. m.

39. *Compression Fractures of the Spine*—Wayland A. Morrison, M.D., and Richard J. Flamson, M.D., 1037 Pacific Mutual Building, Los Angeles.

A review of compression fractures of the spine at the Santa Fe Hospital during the past ten years, with description of a simple method of obtaining hypertension.

Discussion by Francis M. McKeever, M. D., Los Angeles, and Howard W. Fleming, M. D., San Francisco.

40. *Fracture Dislocation of Cervical Spine*—Ralph Soto-Hall, M. D., and Keene Haldeman, M. D., 350 Post Street, San Francisco.

A series of twenty-two cases of fracture dislocation of the cervical spine have been studied to determine the factors which increase efficiency of treatment, diminish nerve injury and prevent recurrence. A new method for the prevention of recurrence of dislocation is described. This method satisfies the theoretical demands of constant but adaptable fixation in hyperextension.

Discussion by Donald King, M. D., San Francisco, and Rodney F. Atsatt, M. D., Santa Barbara.

41. *An Analytical Review of the End-Results in Intracapsular Fractures of the Neck of the Femur*—Merrill C. Mensor, M. D., and Earl T. Dewey, M. D., 490 Post Street, San Francisco.

The paper consists of a study of one hundred consecutive cases admitted to the Laguna Honda Home, with special analysis being made of the allotted time from injury to reduction, complications that ensued, time to ambulation, percentage of union and nonunion, and the end-results relative to function and permanent disability.

Discussion by Frederick C. Bost, M. D., San Francisco, and Paul E. McMaster, M. D., Los Angeles.

42. *New Amputation of the Lower Third of the Thigh*—C. Latimer Callander, M. D., 450 Sutter Street, San Francisco.

This amputation is designed to give an unusually long and powerfully levered stump. Long equal anterior and posterior flaps utilize the soft parts of the upper leg as well as those of the low thigh. No muscles of the thigh are severed except at their tendinous insertions into the tibia. The area of the quadriceps muscle from which the patella is removed serves as a socket for the femur which is sawed within the flare of the condyles.

Discussion by Hugh T. Jones, M. D., Los Angeles, and W. F. Holcomb, M. D., Oakland.

43. *The Management of Fractures of the Shaft of Both Bones of the Forearm or Leg*—E. W. Cleary, M. D., 490 Post Street, San Francisco.

A traction bar facilitates closed reduction. The same device is also utilized for making traction through transfixion wires. A traction frame is used for the most severe multiple and compound injuries. Adaptations are made for traction during operation. Typical case records. (Slides, showing method and results.)

Discussion by Arthur L. Fisher, M. D., San Francisco, and H. W. Spiers, M. D., Los Angeles.

III

OBSTETRICS AND GYNECOLOGY SECTION*

Emil J. Krahulik, M. D., *Chairman*
1021 Taft Building, 1680 North Vine Street
Hollywood

H. A. Stephenson, M. D., *Vice-Chairman*
521 Medico-Dental Building, 490 Post Street,
San Francisco

Donald G. Tollefson, M. D., *Secretary*
511 South Bonnie Brae Street, Los Angeles

First Meeting—Dining Room, Camp Curry
Tuesday, May 14, 8:30 a. m.

44. *Placenta Previa*—Leon J. Tiber, M. D., 3875 Wilshire Boulevard, Los Angeles.

The case histories of two hundred patients treated for placenta previa at the Los Angeles County Hospital have been analyzed. Maternal and fetal mortality for the various types of treatment have been compared.

Discussion by Thomas F. Wier, M. D., San Diego.

45. *Incidental Blindness in Pregnancy*—Donald W. de Carle, M. D., 2000 Van Ness Avenue, San Francisco.

Blindness is a sufficiently rare condition in pregnancy to call attention to its occurrence. It is usually associated with some form of toxemia. The various types of underlying pathology are discussed. The clinical significance is analyzed and its prognosticating value discussed. Of the seven cases reported, four were associated with toxemia, one with pernicious vomiting, one with hysteria, and one with quinin poisoning.

Discussion by Hans Barkan, M. D., San Francisco, and John Vruwink, M. D., Los Angeles.

46. *Mortality Lessons in a Series of Four Thousand and Twenty-nine Gynecologic Operations*—Harold K. Marshall, M. D., 229 North Central Avenue, Glendale, and Robert H. Thompson, M. D., Los Angeles County General Hospital, Los Angeles.

An analysis of the operative deaths on the Gynecological Service of the Los Angeles County Hospital for a six-year period (July 1, 1928, to July 1, 1934), embracing 4,029 primary operations. An attempt has been made to determine factors influencing gynecologic mortality from the standpoint of: (1) Preoperative diagnosis study and preparation. (2) Operation—duration, trauma, technical difficulties, and anesthesia. (3) Postoperative course, treatment, and autopsy findings.

Discussion by L. A. Emge, M. D., San Francisco, and Henry N. Shaw, M. D., Los Angeles.

47. *Clinical Use of Emmenin (Human Placental Extract-Collip)*—Minnie B. Goldberg, M. D., 450 Sutter Street, San Francisco, and Hans Lisser, M. D., 384 Post Street, San Francisco.

Emmenin, an alcohol soluble, ether insoluble extract of human placenta, was described in 1930 by Collip as highly extrogenic in immature rodents, but, unlike estrin, highly active orally. By clinical trial Collip and Campbell claimed this substance to be highly efficacious in the treatment of various menstrual disturbances, notably dysmenorrhea. This is a report concerning the use of emmenin orally in the treatment of one hundred instances of various menstrual disorders. Favorable results occurred in gratifying percentage.

Discussion by C. F. Fluhmann, M. D., San Francisco, and Clifford A. Wright, M. D., Los Angeles.

* Philip H. Arnot, M. D., 490 Post Street, San Francisco, and Sterling N. Pierce, M. D., 1930 Wilshire Boulevard, Los Angeles, are monitors for the Obstetrics and Gynecology Section.

48. *Malignancies of the Vulva* — Paul E. Hoffman, M. D., Stanford University School of Medicine, San Francisco.

The cases of malignancy of the vulva seen in the Stanford Women's Clinic since 1918 are presented, together with a discussion of the etiologic factors in this condition. The relative merits of surgery, irradiation, and combination of both in the treatment are discussed.

Discussion by Clarence A. DePuy, M. D., Oakland, and Lawrence F. Eder, M. D., Santa Barbara.

RECESS

Election of Officers and Business Meeting.

Second Meeting—Dining Room, Camp Curry
Wednesday, May 15, 2 p. m.

49. *Chairman's Address: A Broader Conception of Morbidity Incident to Pregnancy*—Emil J. Krahulik, M. D., 1680 North Vine Street, Hollywood.

Maternal mortality statistics are capable of accurate calculation. Morbidity resulting from pregnancy does not possess such mathematical standards. Elevation of temperature as an index is incomplete and insufficient. In tabulating morbidity statistics, the obstetrician's responsibility should include backache, pelvic pain, lassitude, nervousness, bladder distress, cervical and vaginal lacerations and relaxations, varicose veins, hemorrhoids, pendulous breasts, relaxed abdominal walls, increase in weight, etc.

50. *Relationship of Menstrual Hypoglycemia and Dysmenorrhea*—Milo K. Tedstrom, M. D., 218 South Main Street, Santa Ana, and Llewellyn E. Wilson, M. D., Santa Ana.

Brief résumé of theory of regulation of blood sugar, especially the influence of ovarian and pituitary secretions. Results of glucose tolerance studies made during and between menstruation, showing the relationship of menstrual hypoglycemia and functional dysmenorrhea. Case reports of functional dysmenorrhea treated with extra carbohydrate feedings and intravenous injections of glucose.

Discussion by Harry J. Deuel, Jr., Ph. D., Los Angeles, and Margaret Schulze, M. D., San Francisco.

51. *Arrenoblastoma—Case Report* — L. Grant Baldwin, M. D., 595 East Colorado Street, Pasadena, and James A. Gafford, Jr., M. D., 6118 Santa Fe Avenue, Huntington Park.

Report of case of arrenoblastoma, with removal of tumor, and subsequent recession of masculine characteristics; with opportunity of reëxamination of the pelvis five months later at second laparotomy. (Illustrated with moving pictures and slides.)

Discussion by Ernest M. Hall, M. D., Los Angeles, and C. F. Fluhmann, M. D., San Francisco.

52. *Pelvic Pathology Associated with Mucocele of the Appendix*—T. Floyd Bell, M. D., 400 Twenty-ninth Street, Oakland.

Mucocele of the appendix is usually found accidentally in pelvic operations, or incorrectly diagnosed a tumor of some pelvic organ. Its rarity makes it of interest to all abdominal and pelvic surgeons. Several case reports are presented. The literature is briefly reviewed. Etiology, pathology, symptomatology, treatment, and prognosis are discussed.

Discussion by Don D. Weaver, M. D., Oakland, and Roy E. Fallas, M. D., Los Angeles.

53. *Heart Disease of Pregnancy*—Clarence A. DePuy, M. D., 230 Grand Avenue, Oakland.

This paper deals with the functional classification of heart diseases complicating pregnancy. Endeavors to select that class of patient who will go through pregnancy without disaster, and describes the management during pregnancy, labor and postpartum period.

Discussion by E. M. Lazard, M. D., Los Angeles, and Fred M. Loomis, M. D., Oakland.

IV

EYE, EAR, NOSE, AND THROAT SECTION*

SAMUEL A. DURR, M. D., *Chairman*
1304 Medico-Dental Building
233 A Street, San Diego

DEAN E. GODWIN, M. D., *Vice-Chairman*
800 Professional Building, Long Beach

HAROLD A. FLETCHER, M. D., *Secretary*
1440 Medico-Dental Building, 490 Post Street,
San Francisco

First Meeting—Colonial Room, Ahwahnee
Tuesday, May 14, 8:30 a. m.

55. *Agranulocytic Angina*—William H. Johnston, M. D., 1515 State Street, Santa Barbara.

Reports of this syndrome have appeared in the medical literature since 1888, but it was not until 1922 that Schultz applied the name "agranulocytosis." Evidence shows that there are two types: first, a primary in which the syndrome is the result of no known toxic agent; second, in which it is the direct result of a recognized toxic process which depresses the bone-marrow function. Etiologic factors are considered and the various remedies with the results obtained by many observers are discussed. One case occurring in a middle-aged female is reported in detail. The patient recovered and is in good health three years later.

Discussion by Frank A. Burton, M. D., San Diego.

56. *Facial Nerve Repair*—Robert C. Martin, M. D., 384 Post Street, San Francisco.

Report of three types of facial nerve repair. Probable mode of original injury. Pathology of injured nerve. Technique of operative repair.

Discussion by Sterling Bunnell, M. D., San Francisco, and Howard A. Brown, M. D., San Francisco.

57. *Value of Vestibular Tests in Relation to Head Injuries*—Mark Albert Glaser, M. D., 356 South Rossmore Street, and H. M. Beerman, M. D., 633 South Kenmore Street, Los Angeles.

The series consists of seventy cases of head injury. The relationship between abnormalities in the vestibular tests and dizziness. The value of the vestibular tests in differentiating post-traumatic psychoneurosis, post-concussion syndrome, and malingering is emphasized.

Attempts will be made to draw up vestibular group phenomena associated with head injuries.

Discussion by Howard A. Brown, M. D., San Francisco, and Harold A. Fletcher, M. D., San Francisco.

58. *Reconstruction of the External Ear* — George W. Pierce, M. D., and Gerald Brown O'Connor, M. D., 490 Post Street, San Francisco.

Reconstruction of the external ear has long been considered a useless procedure because of

* Dean E. Godwin, M. D., 820 Professional Building, Long Beach, has been appointed monitor for the Eye, Ear, Nose and Throat Section.

the failure of the reconstructed ear to maintain its shape and angulation to the head. It is most important to have two ears of the same size and shape, and standing out at the same angle to the head.

This paper details our original operation, with description of technique and rationale. Ears constructed by this method do not shrink and will maintain their form. (Lantern slides.)

Discussion by Joseph D. Lewis, M. D., Santa Barbara.

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Second Meeting—Colonial Room, Ahwahnee

Wednesday, May 25, 8:30 a. m.

59. *Surgery of the Ethmoids and Sphenoids*—Frederick M. Turnbull, M. D., 1930 Wilshire Boulevard, Los Angeles.

Relationship of the ethmoids to the other sinuses in development and disease. Special problems involved in their surgery. Choice of operation: comparison of their value from the viewpoints of accessibility and results. Recent experiences with avertin anesthesia and intravenous dextrose therapy as operative aids. Operative technique of the transantral method, with lantern illustrations.

Discussion by Harrington B. Graham, M. D., San Francisco, and Charles E. Futch, M. D., Los Angeles.

60. *Sinusitis, Allergy, and the Common Cold—A New Conception of Their Relationship and of the Function of the Sinuses*—Edward C. Sewall, M. D., Stanford University Hospital, San Francisco.

The evident relationship of allergy to sinusitis, while of etiological importance, has been confused with infection. Infection is always more than allergy and can be definitely determined by a cytological examination of the sinus content. Study of the sinus mucosa in health and disease points the way to an understanding of this relationship. It suggests an explanation for much that is clinically obscure. The incidents of "acute cold"; the character of the discharge; immunity; chronic sinusitis; distinction from "infective cold"; effective aids; atrophic characteristics; reticular fibrosis; bacterial pabulum; virus and the common pus-forming germs.

Explanation of the function of the sinuses has never satisfied all objections. The one I suggest does not either, but is at least provocative.

Discussion by David R. Higbee, M. D., San Diego, and J. Mackenzie Brown, M. D., Los Angeles.

61. *Synthetic Suprarenin Bitartrate as a Mydriatic*—Warren D. Horner, M. D., 384 Post Street, San Francisco

Review of the historical and physiological aspects of the adrenalin family, as used in ophthalmology.

While the pressure-lowering effect is briefly discussed, emphasis is laid upon the mydriatic action of epinephrin compounds. Report of seventy-four cases in which the pupil-dilating effect of levosuprarenin bitartrate (synthetic) was studied in conjunction with J. W. Bettman, acting resident, ophthalmic service at San Francisco Hospital.

The speed of dilatation, the maximum size of the pupil, duration of mydriasis, and the contrary effect of esserin upon the dilated pupil were recorded.

The results are discussed particularly from the standpoint of the practical application of suprarenin bitartrate to everyday ophthalmology.

Discussion by Dewey R. Powell, M. D., Stockton.

62. *Retinal Detachment — Some Technical Points in Its Operative Treatment* — Dohrmann K. Pischel, M. D., 490 Post Street, San Francisco.

The principle brought out by Lindner for walling off the retinal tear or hole, or of walling off a whole sector of retina is discussed. The Safar operation to accomplish this purpose is described, with special reference to some of the technical details, as well as to some pins which have proved very successful. A motion-picture demonstration of a Safar operation will be shown.

Discussion by Frederick C. Cordes, M. D., San Francisco.

RECESS

Election of Officers and Business Meeting

❦

Luncheon Meeting of Otologists

Dining Room, Camp Curry

Wednesday, May 15, 12:30 p. m.

This is an important meeting to discuss the work of the Committee on the Problems of the Deafened, appointed last year. Many points of practical value to the otologist will be brought out in connection with the hearing-aid problem, the audiometer, the Leagues for the Hard-of-Hearing. It is hoped every otologist will attend. Details will be given at registration.

❦

Third Meeting—Colonial Room, Ahwahnee

Thursday, May 16, 8:30 a. m.

63. *Aniseikonia*—Kenneth C. Brandenburg, M. D., 707 Security Building, Long Beach.

The detection and correction of differences in the size and shape of the ocular images by means of the ophthalmo-eikonometer and iseikonic lenses will be discussed. A review of the latest statistics available on the importance of this new factor in the causation of ocular symptoms and the success attained in relieving the various complaints associated with aniseikonia by this new technique will be presented.

Asthenopic symptoms not understood on the basis of the conventional type of refraction may indicate aniseikonia. Refractive errors are sometimes tolerated better than the aniseikonia produced by the ordinary correcting lenses.

Binocular vision with depth perception has been produced in cases of alternating strabismus by the correction of aniseikonia.

A new concept of the phorias is advanced in connection with the phenomenon of fixation disparity. Disturbances of depth perception due to aniseikonia are a factor in the habitual bad landing of aviators.

Discussion by Julian N. Dow, M. D., Los Angeles.

64. *Mode of Action of Cyclodialysis* — Otto Barkan, M. D., S. F. Boyle, M. D., and S. Maisler, M. D., 490 Post Street, San Francisco.

The effect of successful cyclodialysis operation is shown to be due to establishment of communication between the anterior chamber and the suprachoroidal space. Failure is due to reattachment of the ciliary body. Surgical conclusions may be drawn therefrom.

Discussion by M. E. Trainor, M. D., Los Angeles.

65. *Congenital Coloboma, Four Cases—Consideration of Heredity*—Clinton A. Wilson, M. D., Monterey Clinic, Monterey.

Two of the four patients are unrelated persons, both adults, one a man and one a woman. Except for the coloboma the eyes of these patients are within normal limits.

Two patients are related, father and infant son. Older twin daughters of this family and the mother of all three children have normal eyes. The defective left eye of the father is virtually sightless and both eyes of the infant son are abnormally small and show defects of lens, choroid and optic nerve.

Pictures and diagrams, with a brief résumé of embryology and inheritance.

Discussion by Hans Barkan, M. D., San Francisco.

66. *The Nonsurgical Treatment of Nonparalytic Strabismus*—Samuel V. Abraham, M. D., 727 West Seventh Street, Los Angeles.

In this interpretive study, an attempt will be made to point out the errors in the indiscriminate choice of cases for special treatment as orthoptic training. A similar lack of discrimination in the choice of controls to help in evaluating such special treatment will be demonstrated.

Cases suggesting the need for emphasizing the importance of general health factors in the care of patients will be presented. These cases help, too, in pointing out certain fallacies in accepted thought on the value of routine correction of the error of refraction as a prerequisite for successful nonsurgical treatment.

In brief, the author attempts the presentation of a more rational viewpoint of strabismus so that more effective treatment may be instituted and prolonged ineffectual treatment avoided.

Discussion by George N. Hosford, M. D., San Francisco.

V

ANESTHESIOLOGY SECTION

Dorothy A. Wood, M. D., *Chairman*
1390 Seventh Avenue, San Francisco

William V. Chalmers-Francis, M. D., *Secretary*
604 Medical Office Building
1136 West Sixth Street, Los Angeles

First Meeting—Writing Room, Ahwahnee

Tuesday, May 14, 8:30 a. m.

67. *Spinal Anesthesia and the Anesthetist*—W. L. Garth, M. D., 1028 Prospect Street, La Jolla.

Many anesthetists seem to be more or less hostile to spinal anesthesia. This attitude of anesthetists is engendered by the surgeons. Anesthetists should perfect safe technique that can advocate its use.

By briefly outlining the extent of the problem of the proper care of these patients during their operation, the folly of delegating this work to nurses or to inexpericnced physicians will be evident.

68. *Anesthesia in Infant Surgery*—Mary E. Botsford, M. D., 807 Francisco Street, San Francisco.

Extremes of age no bar to safe anesthesia. Report of cases at ages of five hours and ninety-six years. Most frequcnt operative procedures on infants are those for relief of pyloric stenosis, intestinal intussusception, hernia into umbilical cord, and plastic operations on cleft lip and palate. Relative merits of local anesthetics, chloroform, ethyl chlorid, tribromethanol, ether, nitrous oxid. Adaptation of methods of surgical requirements.

69. *Diagnostic and Alcohol Injection of the Sympathetic Nerves*—P. G. Flothow, M. D., and S. N. Berens, M. D., 902 Boren Avenue, Seattle, Washington. (By invitation.)

70. *Chairman's Address: The Development and Progress in Anesthesia*—Dorothy A. Wood, M. D., 1390 Seventh Avenue, San Francisco.

A consideration of the merits and limitations of the various anesthetic agents which have been introduced for use in surgical procedures. The explosive agents—ether, ethylene, vinethine, and cyclopropane. The intravenous anesthetics. The non-explosive anesthetic agents—chloroform, local, spinal, avertin, and nitrous oxid.

RECESS

Election of Officers and Business Meeting

Second Meeting—Writing Room, Ahwahnee

Wednesday, May 15, 8:30 a. m.

71. *Intravenous Anesthesia with Evipal*—Edward H. Bolze, M. D., 450 Sutter Street, San Francisco.

Pharmacology, clinical consideration, dosage, indications and contraindications, personal experiences with the anesthetic agent.

72. *Modern Trends in Anesthesia*—Ralph M. Tovell, M. D., Mayo Clinic, Rochester, Minnesota. (By invitation.)

73. *Caudal and Trans-sacral Anesthesia*—Clark M. Johnson, M. D., 384 Post Street, San Francisco.

Indications, advantages and disadvantages of this method of regional anesthesia. Review of the technique and extent of anesthesia. Summary of results obtained and conclusions reached during the past ten years. (Lantern slides and motion pictures.)

VI

DERMATOLOGY AND SYPHILOLOGY SECTION*

Ernest K. Stratton, M. D., *Chairman*
414 Medico-Dental Building, 490 Post Street
San Francisco

H. Sutherland-Campbell, M. D., *Vice-Chairman*
816 Wilshire Medical Building
1930 Wilshire Boulevard, Los Angeles

John M. Graves, M. D., *Secretary*
430 Medical Building, 909 Hyde Street,
San Francisco

First Meeting—Ping-Pong Room, Ahwahnee

Tuesday, May 14, 8:30 a. m.

SYMPOSIUM ON TREATMENT OF SYPHILIS

74. *Chairman's Address: Review of Some of the Recent Findings in Experimental Syphilis Research*—Ernest K. Stratton, M. D., 490 Post Street, San Francisco.

The cultivation and staining of the Spirochaeta pallida; the question of immunity, reinfection, superinfection; the tropism of certain strains; granular forms; hereditary factors.

75. *Treatment of Acute Syphilis*—Stanley O. Chambers, M. D., 727 West Seventh Street, Los Angeles.

The treatment of early syphilis represents the most important therapeutic phase of the disease when we are concerned with curative possibilities.

Serologic and clinical cure in primary and secondary syphilis is possible in 70 to 95 per cent, depending upon identification with treatment during the darkfield positive, seronegative or the seropositive stage. It is obvious that early identification likewise becomes a most important factor.

The treatment of early syphilis is a most definite one and not subject to major variations unless complicated by abnormal reactions of

* Norman N. Epstein, M. D., 450 Sutter Street, San Francisco, and George F. Koetter, M. D., 1136 West Sixth Street, Los Angeles, are monitors for the Dermatology Section.

drugs, host or invading organisms. Methods of early identification, treatment outlines, and control of complications are thoroughly presented.

Discussion by C. J. Lunsford, M. D., Oakland, and George H. Becker, M. D., San Francisco.

76. *Treatment of Latent Syphilis*—William H. Goeckerman, M. D., 1401 South Hope Street, Los Angeles.

The term "latent syphilis," as used here, means clinically not recognizable syphilis. Treatment in this condition is modified by various factors and should, therefore, not be routinized. Modifying factors are age, Wassermann-fastness, the serologic findings in the spinal fluid, pregnancy in the female, the probability of marriage, and of cardiovascular involvement. There is no doubt that the contagious feature needs treatment. Whether modern treatment prevents future complications is still debatable. My personal opinion is that all forms of latent syphilis need judicious treatment and that the clinical prognosis then in the main is good.

Discussion by George V. Kulchar, M. D., San Francisco, and A. M. Moody, M. D., San Francisco.

77. *Five Years' Observation of the Use of Bismarsen for Congenital Lues*—William A. Reilly, M. D., 711 Seventeenth Avenue, San Francisco.

We have found that this drug compares very favorably with any of the usual antisyphilitic agents. Some fifty of 175 children have been observed for a sufficient period to justify this contention. The drug causes few reactions, it is certainly better borne than the salvarsans, it is easier to administer, and patients are more faithful to treatment. The question of neurosyphilis has been considered also.

Discussion by Stanley O. Chambers, M. D., Los Angeles, and Hartzell H. Ray, M. D., San Mateo.

78. *The Treatment of Ocular Syphilis*—Hans Barkan, M. D., Stanford University Hospital, San Francisco.

Interstitial corneal luetic keratitis; types, age occurrence, and prognosis. The influence of antiluetic treatment upon interstitial keratitis. The appearance of secondary luetic lesions of the iris and ciliary part and treatment. The probability of papillitis in early and late syphilis. Lastly, arteriosclerosis of the retinal vessels as a late luetic manifestation and its differential diagnosis; in general the relation of the eye to antiluetic therapies.

Discussion by Joseph L. McCool, M. D., San Francisco, and H. Sutherland-Campbell, M. D., Los Angeles.

79. *Treatment of Cardiovascular Syphilis*—William W. Newman, M. D., 450 Sutter Street, San Francisco.

The incidence of syphilis among one thousand consecutive patients seen in the private practice of cardiology. The importance of history, physical signs, Wassermann, and particularly x-ray and fluoroscopy in the recognition of cardiovascular syphilis, with practical criteria for a working clinical diagnosis. An evaluation of specific therapy.

Discussion by John J. Sampson, M. D., San Francisco, and John M. Graves, M. D., San Francisco.

80. *Certain Aspects of the Treatment of Neurosyphilis*—Edward W. Twitchell, M. D., 909 Hyde Street, San Francisco.

A symptomatic neurosyphilis. History of the conception. Use of terms. Parenchymatous and meningovascular types. Place of intradural therapy. Pyretotherapy.

Discussion by George S. Johnson, M. D., San Francisco, and Norman N. Epstein, M. D., San Francisco.

Second Meeting—Luncheon

Private Dining Room—Camp Curry

Tuesday, May 14, 1 p. m.

ROUND-TABLE DISCUSSION: BIOCHEMISTRY AS IT IS OF IMPORTANCE IN DERMATOLOGY

Endocrines—Laurence R. Taussig, M. D., 384 Post Street, San Francisco.

Mineral Salts—Kendal P. Frost, M. D., 1930 Wilshire Boulevard, Los Angeles.

Carbohydrates—Georve V. Kulchar, M. D., 450 Sutter Street, San Francisco.

Fats—Frederick G. Novy, Jr., M. D., 360 Twenty-ninth Street, Oakland.

Proteins—Phillip K. Allen, M. D., 314 Medico-Dental Building, San Diego.

Reservations should be made with Dr. Ernest K. Stratton, 490 Post Street, San Francisco, before noon, Monday, May 13.

Third Meeting—Ping-Pong Room, Ahwahnee

Wednesday, May 15, 8:30 a. m.

81. *Clinical Notes on Epitheliomata of the Skin*—Douglass W. Montgomery, M. D., 450 Sutter Street, San Francisco.

The importance of the infiltration border in the diagnosis of epithelioma of the skin. The type of skin on which epitheliomata are most likely to develop. The especially dangerous nature of the cancers that develop in the depth of the skin, both because of lying hidden and because of their greater malignancy. Epitheliomata that show an inveterate tendency to recur.

Discussion by L. R. Taussig, M. D., San Francisco, and Nelson P. Anderson, M. D., Los Angeles.

82. *Experiments on Removal of Hair—A Combined Method*—Arne E. Ingels, M. D., 490 Post Street, San Francisco.

G. Nobl's work on mechanical removal of hair is duplicated in monkeys and checked through histopathological examinations. Successive x-ray treatment in varied doses is being tried out for production of permanent alopecia and checked through biopsies. A short review of work done along these lines will be given.

Discussion by William H. Goeckerman, M. D., Los Angeles, and Professor C. H. Danforth, Stanford University.

83. *Pyodermatoses with Scientific Exhibit*—Nelson Paul Anderson, M. D., and Samuel Ayers, Jr., M. D., 2007 Wilshire Boulevard, Los Angeles.

A review of the common pustular infections of the skin with a brief mention of impetigo contagiosa, ecthyma and sycosis vulgaris. More attention will be given to infectious eczematoid dermatitis, lupoid sycosis, dermatitis papillaris capillitii, recalcitrant pustular eruptions of the palms and soles, granuloma pyogenicum and the uncommon blastomycosis-like lesions of the skin produced by pus-forming organisms.

Discussion by Ernest D. Chipman, M. D., San Francisco, and Franklin Ball, M.D., Los Angeles.

84. *Pigmentation of Metabolic Origin and Its Relation to the Autonomic Nervous System*—Irving R. Bancroft, M. D., 412 West Sixth Street, Los Angeles.

Pigmentation of metabolic origin is dependent on normal glandular secretion, and normal glandular secretion requires a normal balance of the autonomic nervous system. The autonomic nervous system may be thrown out of balance by violent emotion, by syphilis, by toxins of some diseases and by certain chemical poisons.

Discussion by George V. Kulchar, M. D., San Francisco, and Harry P. Jacobson, M. D., Los Angeles.

85. *Sarcoid with the Report of an Unusual Case*—Frederick G. Novy, Jr., M. D., 360 Twenty-Ninth Street, Oakland.

Classification of tuberculids and discussion of sarcoids as a part of this group. Report of a case of mixed type with involvement of bone and nasal mucous membranes.

Discussion by Nelson S. Keeler, M. D., Oakland, and Kendal P. Frost, M. D., Los Angeles.

RECESS

Election of Officers and Business Meeting

❦

Fourth Meeting—Ping-Pong Room, Ahwahnee

Wednesday, May 15, 2 p. m.

86. *Dynamics of Cutaneous Morphology—An Analytical Study*—Moses Scholtz, M. D., 1930 Wilshire Boulevard, Los Angeles.

Evolution of dermatological research, past and present. Morphology, histopathology, and etiology as basic concepts of dermatologic classification. Brock's theories of clinical entities and cutaneous reaction, revised in the light of modern research. Recently differentiated cutaneous syndromes such as lymphoblastoma, poikiloderma, sarcoids, parapsoriasis varioliformis, etc., completely upset the old nosologic established landmarks, and allow new far-reaching theoretical and clinical implications and inferences.

Discussion by Ernest D. Chipman, M. D., San Francisco.

87. *Photosensitivity*—Herman Allington, M. D., 3115 Webster Street, Oakland, Harold F. Blum, Ph.D., and Robert West, Berkeley.

A case is discussed which demonstrates the rapid development of an urticarial plaque throughout any area of skin exposed to sunlight. This is shown to be provoked by light in the blue and violet portions of the visible spectrum. The patient reacts normally to ultraviolet light. Various aspects of photosensitivity are discussed.

Discussion by Edward Matzger, M. D., San Francisco, and Samuel Ayers, Jr., M. D., Los Angeles.

88. *Lymphoblastoma—With the Report of Two Cases*—Louis F. X. Wilhelm, M. D., 1401 South Hope Street, Los Angeles.

A short summary of the subject. A brief review of the literature of recent years. Findings in the cases presented.

Discussion by Harry J. Templeton, M. D., Oakland, and William Goeckerman, M. D., Los Angeles.

89. *Spontaneous Gangrene of Multiple Angiomata in Streptococcic Bacteremia*—Merlin T.-R. Maynard, M. D., 407 Medico-Dental Building, San Jose.

This case in an infant presented multiple hemangiomata over the entire right leg, right buttock, and scrotum; also on the dorsum of the right hand. A sudden ischemia developed with a subsequent gangrene of all of the angiomatous lesions on the body. The baby was found to have a streptococcic bacteremia from which death took place, although the cutaneous lesions were healed. (Photographs will be shown.)

Discussion by Thomas J. Clark, M. D., Oakland.

SCIENTIFIC EXHIBITS

1. *Pyodermatoses*—Nelson Paul Anderson, M. D., and Samuel Ayers, Jr., M. D., Los Angeles.

VII

INDUSTRIAL MEDICINE AND SURGERY SECTION*

WILLIAM S. KISKADDEN, M. D., *Chairman*
803 Wilshire Medical Building
1930 Wilshire Boulevard, Los Angeles

SAMUEL S. MATHEWS, M. D., *Secretary*
1913 Wilshire Boulevard, Los Angeles

First Meeting—Colonial Room, Ahwahnee

Monday, May 13, 2 p. m.

90. *Capitellum Fractures*—Francis M. McKeever, M.D., 1136 West Sixth Street, Los Angeles.

Fractures of the capitellum, humerus, treatment and late end-results.

Discussion by John Dunlop, M. D., Pasadena, and LeRoy Brooks, M. D., San Francisco.

91. *Athletic Injuries*—Packard Thurber, M. D., 901 Subway Terminal Building, Los Angeles.

This paper will deal principally with the rather unusual conditions in connection with athletic injuries, and point out some of the differences between athletic injuries and those occurring under other conditions. The question of treatment will only be considered from the standpoint of fundamentals.

Discussion by George O. Berg, M. D., Los Angeles, and Harold H. Hitchcock, M. D., Oakland, and Earl F. Roth, M. D., Stanford University.

92. *A Study of Five Hundred Traumatic Deaths*—Wallace Dodge, M. D., 727 West Seventh Street, Los Angeles.

This is a study of five hundred fatal traumatic deaths from traffic injuries, taking into consideration the time that had lapsed from the time of injury to the time of immediate treatment, and life expectancy in each case following the different types of injury.

Discussion by Philip H. Stephens, M. D., Los Angeles, and George K. Rhodes, M. D., San Francisco.

93. *The Cost of Industrial Medicine*—T. Sheridan Carey, M. D., 634 North June Street, Los Angeles.

Feeling that there is little understanding as to the actual cost of industrial medicine and the importance of rating traumatic disabilities, I have gone over the cases that have come under my care while surgeon for the Metropolitan Water District of Southern California, and have outlined the rating that I have given the individual case and the amount given by the Commission.

Discussion by R. O. Schofield, M. D., Boulder City, Nevada, and J. M. Meherin, M. D., San Francisco.

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Second Meeting—California Room, Ahwahnee

Tuesday, May 14, 8:30 a. m.

94. *Circulatory Diseases of the Extremities*—Verne R. Mason, M. D., 838 Pacific Mutual Building, Los Angeles.

This is a comprehensive study from a medical aspect on the different types of circulatory disturbances involving the extremities, taking into consideration the diagnosis, progress, and treatment.

Discussion by Steele F. Stewart, M. D., Los Angeles, and Edwin L. Bruck, M. D., San Francisco.

* John Loutzenheiser, M. D., 350 Post Street, San Francisco, and Richard B. McGovney, M. D., 1515 State Street, Santa Barbara, will act as monitors for the Industrial Medicine and Surgery Section.

95. *Regeneration of Cartilages* — Donald King, M. D., Stanford Hospital, San Francisco.

This paper will be the end-results of animal experimental work which is to be carried out at the Stanford University to determine the regeneration of internal semilunar cartilages. The work is being carried out on dogs, and they will be sacrificed at varied periods of time after the operation and the joints studied to determine whether regeneration of the cartilage either in part or *in toto* has occurred.

Discussion by Vernon P. Thompson, M. D., Los Angeles, and Sylvan L. Haas, M. D., San Francisco.

96. *Importance of Lesions of the Intervertebral Discs in Industrial Medicine*—Wilbur Bailey, M. D., and Richard T. Taylor, M. D., 1212 Shatto Street, Los Angeles.

The type of irregularities of the vertebral bodies caused by lesions involving the nucleus pulposus are described, as is the probable influence of trauma in the production of such lesions.

Discussion by Lowell S. Goin, M. D., Los Angeles, and Robert S. Stone, M. D., San Francisco.

97. *Injuries to the Ankle Joint*—Frederic C. Bost, M. D., 384 Post Street, San Francisco.

There are certain types of fractures about the ankle joint which I feel should be opened up for the purpose of repairing the existing torn lateral ligaments.

Discussion by Fraser L. Macpherson, M. D., San Diego, and George C. Hensel, M. D., San Francisco.

98. *Treatment of Spiral Fractures of the Tibia*—Carleton Mathewson, M. D., 1028 Lombard Street, San Francisco.

This paper is to take in the general principle that must be taken into consideration in the treatment of fractures in general, with more or less of a comprehensive review of the past and present views on the healing of fractures and their relationship to the specific treatment of spiral fractures of the tibia.

Discussion by Waldo H. Spiers, M. D., Los Angeles, and Raymond M. Wallerius, M. D., Sacramento.

RECESS

Election of Officers and Business Meeting

VIII

NEUROPSYCHIATRY SECTION*

H. Douglas Eaton, M. D., *Chairman*
811 Medical Office Building
1136 West Sixth Street, Los Angeles

Sydney Kinnear Smith, M. D., *Secretary*
230 Grand Avenue, Oakland

First Meeting—Writing Room, Ahwahnee

Monday, May 13, 2 p. m.

99. *Chairman's Address: The Development of Psychiatry* — H. Douglas Eaton, M. D., 1136 West Sixth Street, Los Angeles.

Historical background — relationship of religions. Recognition of physical causes. Relationship to internal medicine. Psychiatry in California.

100. *Legal Aspects of Insanity*—Mr. R. Lee Chamberlain, 36 Oak Ridge Road, Berkeley. (By invitation.)

This paper will deal with the legal aspects of commitment; responsibility of those taking out commitment papers; matters of guardianship; legal aspects of discharge from the insane status, etc.

Discussion by Benjamin W. Black, M. D., Oakland, and Glenn E. Myers, M. D., Los Angeles.

101. *Insanity as a Legal Defense*—Benjamin W. Black, M. D., Highland Hospital, Oakland.

The plea of "not guilty by reason of insanity" and its significance as a defense in the presence of trial for the commission of a crime.

The privilege of appeal to jury. Jury required by law to make findings in insanity, particularly when the plea is entered as a defense for crime. A summary of the requirements of courts in determination of insanity as a defense for crime.

Consideration of the so-called responsibility and knowledge of right and wrong as exhibited to the physician by persons entering a plea of insanity.

Discussion by Walter Rapaport, M. D., Napa, and J. M. Scanland, M. D., Agnew.

102. *Endocrine Aspects of Homosexuality*—Clifford A. Wright, M. D., 2417 South Hope Street, Los Angeles.

A brief summary of the paper is as follows: The imbalance of sex hormones in relationship to homosexuality will be discussed. An assay of the hormone findings in the urine of several patients will be presented, and treatment based on these findings discussed. Results of treatment will be given.

Discussion by Samuel J. Glass, M. D., Los Angeles, and Edward H. Williams, M. D., Los Angeles.

103. *Schizophrenic Deterioration—An Experimental Study* —Donald A. Macfarlane, M. D., Hotel Claremont, Oakland.

The conditioned reflex technique can be used as an index of organic or other central nervous system deteriorations. In this study two extremes have been employed—organic deteriorates, *i. e.*, the Korsakoff's syndrome on the one hand, or normal persons on the other—the first of which are conditioned without difficulty, or not at all; the latter easily. This criterion has been applied to the Schizophrenic group.

Discussion by Edward W. Twitchell, M. D., San Francisco.

RECESS

Election of Officers and Business Meeting

Second Meeting—Writing Room, Ahwahnee

Wednesday, May 15, 2 p. m.

104. *Therapy in Combined Sclerosis*—Walter F. Schaller, M. D., 909 Hyde Street, San Francisco.

Diversity of opinion regarding efficacy of liver therapy in neurological complications of pernicious anemia. Weight of evidence suggests a common factor causing anemia or nervous tissue changes, or both. Opinion of the authors that adequate treatment arrests the pathological process and effects clinical improvement. Adequate treatment defined. Case reports.

Discussion by Henry W. Newman, M. D., San Francisco.

105. *Arachnoiditis—So-Called, and Differential Diagnosis of Spinal Cord Tumor*—Mark A. Glaser, M. D., 356 South Rossmore Street, Los Angeles, and Frederick Shafer, M. D., 217 West First Street, Los Angeles.

The title is "Arachnoiditis—So-Called." The inadequacy of the term "arachnoiditis" as applied to these cases is emphasized.

Sixty cases of spinal level lesions simulating cord tumor have been subjected to laminec-

* Clifford W. Mack, M. D., Livermore, and Donald A. Macfarlane, M. D., Oakland, will act as monitors for the Neuropsychiatry Section.

tomy, with negative results. Some of these patients have come to autopsy and a detailed pathological study was carried out.

The entire group is taken as an entity and the clinical pictures of these nonsurgical level lesions have been differentiated from spinal cord tumors.

Discussion by Edmund J. Morrissey, M. D., San Francisco, and Howard C. Naffziger, M. D., San Francisco.

106. *Visual Field Alterations Following Craniocerebral Injuries*—Carl W. Rand, M. D., 523 West Sixth Street, Los Angeles.

Examples will be shown of various types of hemianopsia following injuries to the optic chiasm; arteriovenous aneurysm of the internal carotid, and possibly occipital lobe damage. Hysterical contraction of fields, a not uncommon finding in industrial cases, often accompanied by other functional manifestations.

Discussion by Samuel D. Ingham, M.D., Los Angeles, and Clifford B. Walker, M. D., Los Angeles.

107. *Diagnosis in Spinal Cord Tumors*—H. C. Naffziger, M. D., and O. W. Jones, M. D., University of California Hospital, San Francisco.

The paper will concern itself with a classification as to pathologic type, with particular emphasis upon the frequency of hourglass tumors, and tumors of the epidermoid type in relation to the conus medullaris and cauda equina. Certain diagnostic methods have been developed which are original.

Discussion by Carl W. Rand, M. D., Los Angeles.

108. *Apraxia, With Case Reports*—Samuel D. Ingham, M. D., 727 West Seventh Street, Los Angeles.

This paper will deal with the mechanisms of apraxia and will include a number of case reports.

Discussion by Walter F. Schaller, M. D., San Francisco, and J. M. Nielsen, M. D., Los Angeles.

IX

PATHOLOGY AND BACTERIOLOGY SECTION*

Robert A. Glenn, M. D., *Chairman*
Merritt Hospital, Oakland

Rawson J. Pickard, M. D., *Secretary*
805 Watts Building, 520 E Street
San Diego

Zera E. Bolin, M. D., *Assistant Secretary*
490 Post Street, San Francisco

First Meeting—Pavilion, Camp Curry

Monday, May 13, 2 p. m.

SYMPOSIUM ON DISEASES OF THE LIVER

This will be a joint meeting of the following sections: Medicine, Surgery, Pathology and Bacteriology, and Gynecology and Obstetrics Sections.

The program of this joint meeting is printed under the first meeting of the General Medicine Section. (See page 288.)

Second Meeting—Solarium, Ahwahnee

Tuesday, May 14, 8:30 a. m.

109. *Chairman's Address: What the Hospital Means to the Pathologist*—Robert A. Glenn, M. D., Samuel Merritt Hospital, Oakland.

An appreciative consideration of the opportunity provided through hospital affiliation for the development of the pathologist in his chosen field, and to permit him to spread the gospel of scientific medicine among his associates.

110. *Legal, Clinical and Experimental Aspects of Drug Habituation*—L. E. Detrick, Ph.D., and C. H. Thienes, M. D., University of Southern California, Los Angeles. (By invitation.)

The literature on the experimental approach of the problem of narcotic addiction will be reviewed. On the conclusions from such clinical and animal studies, the present-day practice with regard to narcotic drugs should be based. Particular application will be made to the care of the narcotic addict who had pathology; diversion of legal narcotics into illicit drug traffic; the success or failure of narcotic clinics and the improvement in narcotic enforcement.

111. *Mineral Balance in Certain Bone Dyscrasias, with Particular Reference to Osteoporosis*—James W. Sherrill, M. D., Scripps Metabolic Clinic, La Jolla.

Comparison of two-year studies of mineral balance in several bone diseases with disorders of mineral balance. Complete mineral balance studies over a period of a year and a half in a case of obscure osteoporosis. Inferences from complete studies of calcium, magnesium, phosphorus and sulphur balance.

112. *Gastric Ulcers in Sea Mammals*—Charles A. Schroeder, D. V. M., Superintendent, Research Hospital, Zoölogical Society, Balboa Park, San Diego. (By invitation.)

Study of the gastric ulcers constantly found in stomachs of sea elephants and various seals shows them to be caused by a seal round-worm parasitic only in the gastric mucosa. Indirect etiology of food deficiency and other factors considered.

113. *Experimental Studies in the Development of Tolerance to Alcohol*—Emil Bogen, M. D., Olive View Sanitarium, Olive View.

Extent of individual and species differences in susceptibility to alcohol. Hereditary and acquired tolerance. Variations in rate of absorption under different conditions and in different individuals. Differences in rate of oxidation and of excretion of alcohol. Behavior of different individuals with the same concentration of alcohol in the blood and brain.

Discussion by C. H. Thienes, M. D., Los Angeles, and J. C. Geiger, M. D., San Francisco.

114. *Symmetrical Renal Cortical Necrosis in Eclampsia, with Case Report*—Newton Evans, M. D., 2000 Milan Avenue, Los Angeles.

Reference is made to similar cases previously reported. The history of previous eclamptic attacks and a final fatal attack in a 39-year-old woman are presented. The postmortem findings as well as microscopic changes in the kidneys are described. A toxemia related to pregnancy, with widespread thrombosis of small arteries, arterioles and capillaries of the renal cortex, are presented as the explanation of the pathogenesis of the condition.

Third Meeting—Solarium, Ahwahnee

Wednesday, May 15, 8:30 a. m.

115. *A Twenty-Year Appraisal of a Modification of the Original Wassermann Test*—Robert B. Hill, M. D., 511 South Bonnie Brae, Los Angeles.

In the past twenty years, papers on tests for syphilis have nearly all presented new methods, each simpler and quicker than the other. This is a presentation of reasons why it so often happens that the original Wassermann continues in use in laboratories directed by physicians.

Discussion by E. H. Ruediger, M. D., San Diego, and R. J. Pickard, M. D., San Diego.

* Paul H. Guttman, M. D., 1127 Eleventh Street, Sacramento, A. Ludwig Lindberg, M. D., 1407 South Hope Street, Los Angeles, and Zera E. Bolin, M. D., San Francisco, will act as monitors for the Pathology Section.

116. *The Asheim-Zondek Test*—E. H. Ruediger, M. D., Mercy Hospital, San Diego.
Results in various conditions of pregnancy and diseases and tumors of the pelvic organs. Quantitative studies, resistance of the hormone.

117. *Coccidioidal Granuloma*—J. H. Inman, M. D., 1830 Flower Street, Bakersfield.
Lantern slides of clinical, x-ray, gross and microscopic findings of series of cases seen in Kern County during the past two years.

118. *Pathology of Sudden Operative Death*—Paul Michael, M. D., 434 Thirtieth Street, Oakland.
Enumeration and discussion of twelve causes of sudden death occurring on the operating table. Analysis of those cases coming under thymicolymphatic constitution. Explanation of the physiology of this syndrome and the mechanism of death given. (Lantern slides.)
Discussion by A. M. Moody, M. D., San Francisco.

119. *First Annual Review of the Contagious Disease Situation in California*—W. H. Kellogg, M. D., Director of the State Bacteriological Laboratory, Berkeley. (By invitation.)
Review of the state of progress or regression of the commoner contagious diseases in the State as of the present year.

RECESS

Election of Officers and Business Meeting

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Fourth Meeting—Solarium, Ahwahnee

Thursday, May 16, 8:30 a. m.

120. *Tumors of the Testis*—George D. Maner, M. D., 657 South Westlake Avenue, Los Angeles.
Paper based on the histopathologic study of twenty-five consecutive malignant tumors removed surgically. Effort is made to confirm the dictum that all malignant tumors of the testes are heterologous (teratomatous) in type. Brief review of various classifications and theories of histogenesis is given.

121. *Nucleolar-Nuclear Ratio in Cancer—A Statistical Study*—Paul H. Guttman, M. D., 1127 Eleventh Street, Sacramento.
Determination of the ratio between the volumes of nuclei and nucleoli of malignant and nonmalignant growths by micrometer measurements.

122. *The Fundamental Principles in the Grading of Malignancy in Tumors* — A. Ludwig Lindberg, M. D., 1407 South Hope Street, Los Angeles. (Thirty-minute lantern slide demonstration.)
Broders' classical work in the grading of malignancy of tumors is based on the cytological deviation from normal, Hausemann's anaplasia. The grading of tumors facilitates correlation of the pathological and clinical data and is an important guide in the management of cancer. The lantern slides demonstrate the fundamental principles.
Discussion by R. A. Glenn, M. D., Oakland.

123. *Observations on the Biophysical Mechanisms of Cancer*—Lloyd A. Kennell, M. D., 908 Watts Building, San Diego.
An interpretation of the interrelationship oxidation-reduction reactions, enzyme action, catalytics and colloidal gelsol factors involved in the mitosis of the cancer cell, together with the action of silicon in the surrounding tissues as a factor in their resistance to invasion by the cancer cells. Effects of radiation frequencies other than those of the x-ray and radium as adjuvants in therapy with means of concentrating them in deep tissues.
Discussion by Montrose T. Burrows, M. D., Pasadena; James W. Sherrill, M. D., La Jolla; and Professor Murray Luck, Palo Alto.

X

PEDIATRICS SECTION*

HENRY E. STAFFORD, M. D., *Chairman*
242 Moss Avenue, Oakland

SAM J. MCCLENDON, M. D., *Secretary*
2001 Fourth Street, San Diego

EDWARD B. SHAW, M. D., *Assistant Secretary*
384 Post Street, San Francisco

First Meeting—Solarium, Ahwahnee

Monday, May 13, 2 p. m.

124. *Brain Tumors in Children—Case Reports*—Alfred J. Scott, M. D., 1401 South Hope Street, Los Angeles.
Brain tumors in children are not uncommon and too often are fatal. The diagnosis is not always easy, as it is not suspected and often overlooked until too late.
Three cases of brain tumors are presented only one of which was operated with recovery. The principal symptoms and signs are discussed. Lantern slides are presented showing the microscopic structure of two of these conditions.
Discussion by Carl W. Rand, M. D., Los Angeles, and Orville N. Meland, M. D., Los Angeles.

125. *Anemias in Infancy*—Madeleine A. Fallon, M. D., Children's Hospital, Los Angeles. (By invitation.)
Normal blood levels in infants. Iron deficiency anemias in prematures, twins, infants of low birth weight, infants born of anemic mothers, and in infants on inadequate diet. Symptoms, physical findings, and blood pictures in these anemias. Response to therapy. Other types of anemias in infancy.
Discussion by Hugh K. Berkley, M. D., Los Angeles.

126. *Congenital Ichthyosis (Collodion Skin)*—Roland P. Seitz, M. D., 490 Post Street, San Francisco.
This rare condition is described as seen in a newborn and at intervals during the first year. The description is supplemented by photographs and a biopsy. A review of the literature is given.
Discussion by Thomas J. Clark, M. D., Oakland.

127. *Diphtheria Immunization*—Lillian Kositza, M. D., 116 West Temple Street, Los Angeles. (By invitation.)
A ten-year survey of progress in diphtheria immunization in Los Angeles, as conducted through the Los Angeles City Health Department, is presented. About 84,575 children were immunized between the years 1924-1934. Forty-six thousand six hundred and sixteen with toxin antitoxin, 35,946 with toxoid, and 2,013 with alum precipitated toxoid.
Discussion by Milton L. Halverson, M. D., Pasadena, and A. J. Scott, M. D., Los Angeles.

128. *The Incidence of Rachitic Imperfections in Children*—C. U. Moore, M. D., Medico-Dental Building, Portland, Oregon. (By invitation.)
A review is given of the skeletal imperfections noted in the routine office examination of consecutive cases seen during recent years. These are analyzed according to age and to the character of the active signs or residual stigmata. Anterior and lateral posture gradings are noted in the older children.

* E. E. Moody, M. D., 3780 Wilshire Boulevard, Los Angeles, and William Reilly, M. D., 711 Seventeenth Avenue, San Francisco, will act as monitors of the Pediatrics Section.

The purpose of this study is to determine the incidence of mild rachitic unfitness and the need for discussion of various prophylactic measures.

Discussion by E. E. Moody, M. D., Los Angeles, and W. C. Deamer, M. D., San Francisco.

129. *Treatment of Congenital Deformities*—W. S. Kiskadden, M. D., 1930 Wilshire Boulevard, Los Angeles.

Theories of etiology of congenital deformities. Review of cases of harelip, cleft palate, maldeformities of the ear, cheek, as well as consideration of syndactylism, polydactylism and associated deformities of the hands and feet. (Lantern slides.)

Discussion by H. O. Bames, M. D., Los Angeles, J. Homer Woolsey, M. D., Woodland, and Gerald B. O'Connor, M. D., San Francisco.

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Second Meeting—Solarium, Ahwahnee

Wednesday, May 15, 2 p. m.

130. *Chairman's Address: Changing Pediatric Practice*—Henry E. Stafford, M. D., 242 Moss Avenue, Oakland.

There has been a marked change in the progress of pediatrics in the last few years. Increasing emphasis is being placed upon preventive procedures for postural defects, endocrine disorders, psychological maladjustments, and late sequelae of infectious diseases. The importance of securing the coöperation of the laity by education will be stressed.

SYMPOSIUM ON CHILDHOOD ENDOCRINOLOGY

131. *Endocrinological Problems in Pediatrics*—Oscar Reiss, M. D., 1930 Wilshire Boulevard, Los Angeles.

Observations are recorded of changing impressions regarding endocrinology during the past thirty years. A statement is made of what is accepted knowledge at this date. Its application to pediatric practice is pointed out. Future developments are envisaged.

Discussion by William Reilly, M. D., San Francisco.

132. *The Subthyroid Child*—Edward J. Lamb, M. D., 1515 State Street, Santa Barbara.

Clinical picture of various aspects and manifestations of hypothyroidism, including failure to gain in weight and in height, and allergic reactions. Discussion of diagnostic points and case reports.

Discussion by Donald K. Woods, M. D., San Diego, and Helen B. Pryor, M. D., San Francisco.

133. *Adrenal Endocrinopathies in Childhood*—H. Clare Shepardson, M. D., 384 Post Street, San Francisco.

Disturbances in function of the adrenal glands are unusual. There are, however, certain alterations in function of both the cortical and medullary portions of the adrenal glands which result in definite symptom complexes. These occur in children as well as adults. A brief outline of these conditions will be given together with some suggestions as to treatment.

Discussion by Rieta C. Hough, M. D., San Diego.

134. *Endocrine Factors in Calcification*—Francis Scott Smyth, M. D., University of California Hospital, San Francisco.

The rôle of the endocrine glands in calcification is not a simple one. At present it is often difficult to differentiate, clinically, primary from secondary parathyroid involvement. Thyroid, pituitary and even the liver and spleen, have been considered as having a possible hormonic influence. Until the mystery of the interrelationship of the endocrine glands is better understood, caution should be exercised regarding wholesale adoption of surgical treatment. Knowledge already accumulated on the nutritional, digestive and excretory factors in calcification must not be forgotten.

Discussion by William W. Belford, M. D., San Diego, and Leon Goldman, M. D., San Francisco.

RECESS

Election of Officers and Business Meeting

XI

RADIOLOGY SECTION*

KENNETH S. DAVIS, M. D., *Chairman*
St. Vincent's Hospital
2131 Ocean View Boulevard, Los Angeles

ALFRED C. SIEFERT, M. D., *Secretary*
411 Thirtieth Street, Oakland

First Meeting—Tudor Lounge, Ahwahnee

Monday, May 13, 2 p. m.

135. *Chairman's Address*—Kenneth S. Davis, M. D., St. Vincent's Hospital, Los Angeles.

136. *Comments on the Fourth and Fifth International Congresses of Radiology*—Albert Soiland, M. D., 1407 South Hope Street, Los Angeles.

Radiology has made phenomenal professional advances during the past thirty years. In Europe this specialty has drawn from the best in the profession, with America following. The Fourth International Congress in July of 1934 at Zurich was an outstanding event, with over twelve hundred medical delegates in attendance, representing forty-three nations. America is now looking forward to the Fifth International Congress, which will be held in Chicago in September of 1937. A united American delegation is sponsoring this Congress, and visitors are welcome.

137. *A Comparison of 800 Kv. with the 200 Kv. Roentgen Ray*—Henry Schmitz, M. D., 25 East Washington Street, Chicago. (By invitation.)

138. *Roentgenological Differentiation Between Acute Intestinal Obstruction and Paralytic Ileus*—LeRoy Santa, M. D., Professor of Radiology, St. Louis University School of Medicine, St. Louis, Missouri. (By invitation.)

Roentgenological manifestations of acute intestinal obstruction are described and many types of obstruction are illustrated. Points of differentiation between acute intestinal obstruction and paralytic ileus are stressed. Difficulties arising from the coexistence of the two conditions are pointed out. The necessity for correlation of x-ray findings with clinical picture is clearly shown.

139. *The American Board of Radiology*—B. R. Kirklin, M. D., Mayo Clinic, Rochester, Minnesota. (By invitation.)

There will be open discussion of the above papers.

Meeting of the Pacific Roentgen Club.

RECESS

Election of Officers and Business Meeting

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Tuesday, May 14, 1 p. m.

Ahwahnee Hotel

There will be a luncheon given to members of the American Board of Radiology by the Pacific Roentgen Club.

*Elmer N. Liljedahl, M. D., 215 Chadbourne Avenue, Los Angeles, will act as monitor for the Radiology Section.

Second Meeting—Dining Room, Camp Curry
Wednesday, May 15, 2 p. m.

SYMPOSIUM ON DIAGNOSIS AND TREATMENT OF LESIONS OF THE STOMACH

This will be a joint meeting of the Sections on General Surgery and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Surgery Section. (See page 291.)

Third Meeting—Tudor Lounge, Ahwahnee
Thursday, May 16, 8:30 a. m.

140. *The Pars Cardia of the Stomach, Radiologically Considered*—Jacob Abowitz, M. D., 4833 Fountain Avenue, Los Angeles.

Carcinoma of the pars cardia. Roentgenological findings: elevation of the left diaphragm with loss of function; distortion of gas bubble (Magenblase); visualization of tumor through gas bubble; filling defect in stomach wall; speck of barium at the pars cardia of the stomach and cardiac end of the esophagus; and absence of peristalsis. Diaphragmatic hernia of the pars cardia of the stomach. Pouch of the pars cardia of the stomach.

Discussion by Clyde K. Emery, M. D., Los Angeles.

141. *Air in the Hepatic Ducts, an X-Ray Sign of Gall-Bladder Fistulae*—Robert A. Powers, M. D., 261 Hamilton Avenue, Palo Alto.

Although four hundred or more cases of gallstones ileus have been reported in the literature, practically no mention is made of the value of roentgen examination. In a few isolated cases there are reports of barium in the hepatic ducts, but other x-ray findings are rarely mentioned. The author presents four cases, in three of which the diagnosis was possible without the administration of barium. Two cases showed well-defined tubular air shadows in the hepatic ducts, and a third one, indirect evidence of fistula. As a diagnosis of this condition is rarely made before operation, roentgen findings are important, and when considered in conjunction with the history of clinical findings, should result in a higher percentage of preoperative diagnoses.

Discussion by Daniel M. Clark, M. D., Santa Barbara.

142. *Visualization of the Bile Ducts in Course of Examination of the Gastro-Intestinal Tract by Barium Meal*—James B. Bullitt, M. D., 303 Medico-Dental Building, San Jose.

The literature records a number of instances of visualization of the bile ducts in cases of biliary fistulae. The case reported is one of apparently visualization of bile ducts by filling from the duodenum through the intact common duct.

Discussion by Daniel M. Clark, M. D., Santa Barbara.

143. *A Roentgen and Statistical Study of Intestinal Obstruction*—John F. Chapman, M. D., 65 North Madison Avenue, Pasadena.

Purposes to determine—accuracy of positive and negative diagnoses. Other conditions presenting similar appearance. Time between beginning of symptoms and positive roentgen sign. The least findings safe for positive diagnosis. Conditions found at operation in the series.

Discussion by Carl B. Bowen, M. D., Oakland.

144. *Observations on the Duration of X-Ray Evidence of Skull Fracture*—Edward S. Blaine, M. D., 727 West Seventh Street, Los Angeles.

A study of a series of skull fractures of various types, attempting to provide a basis for correct answer of the often asked question, "How long does the x-ray show a skull fracture?"

Discussion by Mark A. Glaser, M. D., Los Angeles.

145. *Observations on the Roentgen Treatment of Certain Types of Arthritis*—L. Henry Garland, M. D., 450 Sutter Street, San Francisco.

The roentgen treatment of arthritis, at least for the relief of its painful manifestations, was first reported by Sokoloff in 1897. Since then many papers have appeared on the subject, but on the whole this valuable adjunct in therapy has been rather neglected. The present paper is a report on the results of treatment in fifty cases seen at the San Francisco City and County Hospital during the last few years. Thirty-nine of the cases were of acute infectious type (the majority being cases of gonorrheal arthritis); the remainder were of the chronic infectious and degenerative types.

Discussion by Orville N. Meland, M. D., Los Angeles.

XII

UROLOGY SECTION*

GEORGE F. SCHENCK, M. D., *Chairman*
308 Wilshire Medical Building
1930 Wilshire Boulevard, Los Angeles

THOMAS E. GIBSON, M. D., *Secretary*
911 Four Fifty Sutter Street
San Francisco

First Meeting—Ping-Pong Room, Ahwahnee
Monday, May 13, 2 p. m.

146. *Chairman's Address: The Incidence of Urologic Pathology as Found in One Thousand Consecutive Autopsies* — George F. Schenck, M. D., 1930 Wilshire Boulevard, Los Angeles.

The author has tabulated the incidence of urologic pathology as it occurs in tuberculosis, cardiovascular diseases, carcinoma, septic, and a miscellaneous group of one thousand consecutive cases studied at autopsy. The aforementioned groups are tabulated by decades, and the intimate relation and importance of urinary pathology are graphically illustrated to show their primary or contributory influence on mortality.

SYMPOSIUM ON URINARY EXTRAVASATION

147. *Urinary Extravasation*—J. C. Negley, M. D., 527 West Seventh Street, Los Angeles.

Etiology, spontaneous from conditions within the patient, as stricture, calculi, destructive disease process, etc. Extraneous, as from instrumental or other trauma. Diagnosis—clinical findings and symptoms, x-ray, laboratory, exploratory operation. Treatment—conservative by catheter or incisional drainage.

148. *Traumatic Injuries of the Deep Urethra and Adnexae With or Without Fracture of the Pelvis*—Harry W. Martin, M. D., 6253 Hollywood Boulevard, Los Angeles.

Incidence much greater in present age of industrial production and traffic accidents than formerly, as stressed in classical textbooks. Straddle injuries comparatively unimportant as compared with new types of injuries common in the last fifteen or twenty years. Discussion and analysis of methods of systematic examination requisite for determination of most

*A. G. Folte, M. D., 870 Market Street, San Francisco, and James B. Herring, M. D., 490 Post Street, San Francisco, are monitors for the Urology Section.

satisfactory management of this type of case. Much stress laid on early and adequate drainage even in doubtful cases in order to insure against immediate or future urologic morbidity, and even mortalities.

149. *Serial Motion Picture Demonstrating the Management of Urinary Extravasation*—Carl F. Rusche, M. D., and Samuel K. Bacon, M. D., 1680 North Vine Street, Hollywood.

This paper presents a discussion of acute urinary extravasation following urethral stricture and the preoperative diagnosis, surgical procedure and postoperative management is shown by a serial motion picture.

Discussion of symposium by George C. Reinle, M. D., Oakland; H. A. R. Kreutzmann, M. D., San Francisco; Lloyd E. Kindall, M. D., Oakland; and Nathan G. Hale, M. D., Sacramento.

150. *The Rôle of the Female Urethra in Urology*—William E. Stevens, M. D., 870 Market Street, San Francisco.

Relative frequency of urethral pathology in lesions of the female urinary tract. Examination of the female urethra. Urethral glands. Urethritis. Strictures. Tumors. Calculi. Urethrocele. Roentgenography.

Discussion by H. C. Bumpus, M. D., Pasadena, E. W. Beach, M. D., Sacramento, and Frank S. Dillingham, M. D., Los Angeles.

Second Meeting—Tudor Lounge, Ahwahnee

Tuesday, May 14, 8:30 a. m.

151. *Postrenal Anuria*—Thomas I. Buckley, M. D., 251 Moss Avenue, Oakland.

Report of a case of anuria of six days' duration due to bilateral ureteral block by symptomless calculi. The surgical procedure, the postoperative course, and the autopsy findings to be discussed. General discussion of anuria.

Discussion by Robert V. Day, M. D., Los Angeles; W. W. Cross, M. D., Oakland; E. F. Chamberlain, M. D., San Diego; and Lewis Michelson, M. D., San Francisco.

152. *Pyelonephrostomy for Stone in the Single Kidney—Report of Three Cases*—Burnett W. Wright, M. D., 1137 Roosevelt Building, and Wilbur G. Rogers, M. D., 523 West Sixth Street, Los Angeles.

Three cases are presented for which pyelotomy or pyelonephrostomy for stone was done in the remaining kidney. Two of the patients were subjected to surgical removal of their calculi before much harm had been done to their kidneys. These two patients are now living useful lives. One of the patients did not come to surgery until more than three years after the original diagnosis of a staghorn calculus in her remaining kidney. She was in uremia and the removal of her calculus did not materially prolong her life. Other things being equal, patients with single kidneys withstand surgical manipulations of these kidneys as well as patients having both kidneys.

Discussion by A. A. Kutzmann, M. D., Los Angeles; Albert M. Meads, M. D., Oakland; J. Salem Rubin, M. D., Los Angeles; and J. J. Crane, M. D., Los Angeles.

153. *Two Cases of Carcinoma of the Bladder of Allantoic Origin*—Paul A. Ferrier, M. D., 65 North Madison Avenue, Pasadena.

Report of a case of carcinoma of the bladder with intestinal type of mucosa, apparently originating in the remnant of the allantoic duct. Operation with ten-year cure. Second case with autopsy findings. Review of previously reported cases.

Discussion by A. J. Scholl, M. D., Los Angeles; George W. Hartman, M. D., San Francisco; B. H. Hager, M. D., Los Angeles; and Lionel P. Player, M. D., San Francisco.

154. *Kidney-Liver Syndrome*—James Steinberg, M. D., 1052 West Sixth Street, Los Angeles.

Obstructive pyonephrosis of kidney as etiologic factor in production of acute reflex toxic jaundice in previously normal liver and gallbladder. Recovery of acute cholemia following removal of pyonephrotic focus. Tracing mechanism of the acute cholemia by comparative study of the liberation of toxic foreign proteins in the circulation, with liver shock in taking up the function of detoxification.

Discussion by Louis C. Jacobs, M. D., San Francisco; Leon I. Oppenheimer, M. D., Oakland; and Charles P. Mathé, M. D., San Francisco.

155. *Heat in the Treatment of Prostatitis*—James B. Herring, M. D., 490 Post Street, San Francisco. Urologists agree that elevating the temperature of the prostate has therapeutic value, but are not in accord as to its production. Just as many doctors depend to a large extent upon the detail men for their therapeutics, so urologists buy their electrical apparatus upon the representation of the salesman. Elevation of temperatures in the prostate can be accurately determined by means of thermocouple recordings. Demonstration of comparative values of diathermy, radiofrequency, infra-red, Elliott, and other alleged heat-producing machines. (Lantern slides.)

Discussion by A. Elmer Belt, M. D., Los Angeles; George Stilson, M. D., Long Beach; Wirt B. Dakin, M. D., Los Angeles; F. H. Redewill, M. D., San Francisco.

RECESS

Election of Officers and Business Meeting

XIII

CANCER COMMISSION—SUNDAY CONFERENCES

Pathology and radiology conferences are planned, as usual, for Sunday, May 12, immediately before the California Medical Association convention. Both will be at the Ahwahnee Hotel, Yosemite, from 10 a. m. to 5 p. m., with lunch intermission.

Members wishing to attend either conference should register at once with the secretary of the Commission, 450 Sutter Street, San Francisco, or with the chairmen of arrangements committees: Radiology, Dr. L. H. Garland, 450 Sutter Street; Pathology, Dr. Z. E. Bolin, 490 Post Street, San Francisco.

For the pathology conference it is essential that members register, as space and material will be limited to forty. For the radiology conference, it is necessary to know the number desiring to attend, since national society examinations are to be held in San Francisco the same day, and unless a sufficient number register for the Yosemite conference it may have to be canceled.

Microscopes must be brought by those attending the pathology conference. No extra ones will be available at Yosemite.

Members attending either conference will need to reach the Valley the night before, if traveling by rail and bus; or, if motoring, should plan to stop at Merced Saturday night in order to arrive by 10 a. m.

PRE-CONVENTION BULLETIN

Section 3 of Article XII of the California Medical Association Constitution states in part: "The Association, prior to the annual session, shall print a 'Pre-Convention Bulletin,' which shall contain reports of officers and committees. . . . A copy of the 'Pre-Convention Bulletin' shall be given to each delegate and alternate, on or before registration."

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

Since the organization of the California Medical Association, there have never been so many vital measures before the Council for consideration and decision as during the last two years.

The Council of the California Medical Association has for many years had its share of work to do. Reports of all committees must be submitted to the Council for final action, and the Council "must go on record as either being in favor of, against, or simply neutral."

It seems that the work of the Council, in reference to public health measures and legislation, has just begun, as many more public health acts and bills must be considered before the adjournment of the present legislature. This body will be in session until the last of May, 1935, and probably longer.

There has been so much activity during the last two years that required immediate and special attention that the officers, Council, and individual members of the California Medical Association have visited nearly all of the component county medical societies to discuss with the members the necessity of complete organization to combat those things that were proposed by individuals who hoped that their measures and initiatives might lower the standards of medicine and public health laws, to allow untrained practitioners of most any cult to thrive at the expense of the sick people of the State of California.

The standards of education and experience of the medical profession in this State are very high. Seventy-five hundred to eight thousand licentiates of the doctors of medicine are conscious of these requirements, and have always insisted that one lives up to them.

As a result, the full membership of the California Medical Association sensed "the call to arms" last November to maintain the reputation of educated and honest men of the medical profession. Full coöperation prevailed, and as a result we are holding our heads high and saying to the medical world that the doctors of medicine in California still believe in the advancement of scientific medicine and full protection of the people of the State of California.

As president of the California Medical Association, I have visited all the component county medical societies except three. At each meeting, two to five members of the California Medical Association accompanied me. These associates addressed the members. We were especially active before the primaries and the final election of November 6, 1934.

Doctors Edward M. Pallette, Alson Kilgore, Harry H. Wilson, J. B. Harris, W. W. Roblee, F. C. Warnshuis, Glenn E. Myers, Edmund T. Remmen, William C. Voorsanger, Charles Regan (the dentist), Mr. Stanley Cochems, and Mr. Ben Reed were the principal speakers. From this group we arranged a program, each speaker discussing a different problem that would convey information to the entire membership of the California Medical Association.

At all the meetings I was much impressed with the honesty of purpose of all the members, and their sincere belief that the California Medical Association had the interest of each member at heart.

The California Medical Association is proud indeed to know that throughout the State its members are the leading men in every community in civic affairs as well as in medicine.

Dr. Walter Biering, president of the American Medical Association, said he believed that the medical profession in California is the most active body of men in the states—thoroughly scientific, leaders in medicine, and more interested in the problems of government (whether municipal, county, state, or federal) than in most states visited by him during his term of office.

All of our committees have worked very diligently toward an objective, never shirking. Many have attended meetings of the committees when it was a hardship to them individually, but loyalty to the California Medical Association made it easy for them to perform their duties.

Space will not permit me to refer to the activities of all the committees. This information will be published in our state JOURNAL during the next year.

The officers of the California Medical Association could do very little for scientific medicine if it were not for the hearty coöperation of all departments.

Your Council, Executive Committee, Public Relations Committee, Committee on Public Health and Legislation and special committees, and the component county societies, form such a well-stabilized group that the organization really does not need a president.

The members of the California Medical Association must realize that the Council has had three times as many meetings as in previous years. The members of your Council have been in session two days many times this year. Mr. Hartley F. Peart, your legal counsel, has always been present at these meetings. His good advice has directed the Council over many difficult obstacles.

Dr. Frederick C. Warnshuis, our newly elected secretary, knows the needs of our Association. He is thoroughly conversant with organized medicine—a man whose contacts with leaders of organized and scientific medicine throughout the United States cannot help but bring real benefit to the California Medical Association. He has said, many times in public, that the office at Four Fifty Sutter Street, San Francisco, belongs to the members of the California Medical Association, and he wishes it to be known that he is willing at all times to do his part toward the successful management of the departments under his direction, and invites you to call.

It seems to me, gentlemen, that the California Medical Association is on its way to accomplish bigger things, and to keep in motion protective health laws for the people of our State.

I am sorry my year of service is nearly over. I have contributed but little. However, it has been enjoyed and I have learned much about the necessity of organized medicine.

Please accept my thanks for all your courtesies.

Respectfully submitted,

Clarence G. Toland, *President.*

REPORT OF PRESIDENT-ELECT

To the President and the House of Delegates:

The president-elect of the California Medical Association is ex-officio member of the Council, member of the Executive Committee, and a member of the Department of Public Relations.

Your president-elect has, during the past year, attended all meetings of these bodies, with the exception

of those held during his absence from California between August 6 and October 17, 1934.

He is also one of the Committee of Five, holding this appointment from the chairman of the Council. The president-elect has attended all meetings of the Committee of Five, except those held during his absence from the State.

Respectfully submitted,

Robert A. Peers, *President-Elect.*

REPORT OF THE COUNCIL

To the President and the House of Delegates:

This report will be mailed to all delegates ten days before the annual session. This procedure is being observed in order that this report may cover all Association work up to the time of the annual session.

Frederick C. Warnshuis,
Secretary-Treasurer.

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

During the past year, as during the previous six years, the Speaker has regularly attended the meetings of the Executive Committee and the Council of the California Medical Association, of which bodies he is ex officio a member. He has also served as trustee of the California Medical Association and of the Medical Society of the State of California. With other officers, he has attended numerous medical meetings throughout the State.

The Speaker desires to thank the members of the House of Delegates and its committees for their cordial coöperation.

At the Yosemite annual session, the House of Delegates will meet on Monday and Wednesday evenings, promptly at eight o'clock. All resolutions to come before the House must be presented at the meeting on Monday evening.

Respectfully submitted,

Edward M. Pallette, *Speaker.*

REPORT OF SECRETARY-TREASURER

To the President and the House of Delegates:

I have the honor to transmit to you and through your body to the membership this annual report as secretary-treasurer for the fiscal year of 1934.

MEMBERSHIP

The membership of the Association is reflected by the following statistical report:

CALIFORNIA MEDICAL ASSOCIATION

Membership as of December 31	1933	1934	Gain	Loss
Alameda	451	471	20	..
Butte	18	18	..	..
Contra Costa	44	43	..	1
Fresno	109	113	4	..
Humboldt	29	31	2	..
Imperial	26	23	..	3
Kern	49	48	..	1
Kings	8	18	10	..
Lassen-Plumas	9	10	1	..
Los Angeles	1,961	2,000	39	..
Marin	33	33	..	..
Mendocino	19	20	1	..
Merced	21	24	3	..
Monterey	44	46	2	..
Napa	25	27	2	..
Orange	106	107	1	..
Placer	27	29	2	..
Riverside	56	60	4	..
Sacramento	134	132	2	..
San Benito	5	5	..	..
San Bernardino	117	119	2	..
San Diego	222	227	5	..
San Francisco	774	775	1	..
San Joaquin	78	86	8	..
San Luis Obispo	22	25	3	..
San Mateo	45	49	4	..
Santa Barbara	99	99	..	..
Santa Clara	163	168	5	..
Santa Cruz	32	30	..	2
Shasta	10	11	1	..
Siskiyou	16	20	4	..
Solano	21	23	2	..
Sonoma	44	47	3	..
Stanislaus	36	38	2	..
Tehama	12	12	..	..
Tulare	37	37	..	..
Ventura	33	32	..	1
Yolo-Colusa-Glenn	26	25	..	1
Yuba-Sutter	10	11	1	..
	4,972	5,094	138	9
Associate members	5	6	..	..
Honorary members	14	12	..	..
Retired members	57	57	..	..
Total	5,043	5,169		

DELINQUENT MEMBERS

On December 31, 1934, the records disclose the following number of delinquents, by counties:

County	Number
Alameda	7
Contra Costa	2
Fresno	3
Humboldt	1
Imperial	3
Kern	2
Lassen-Plumas	1
Los Angeles	61
Marin	1
Monterey	1
Orange	6
Sacramento	2
San Bernardino	1
San Diego	8
San Francisco	23
San Joaquin	1
Santa Barbara	2
Santa Clara	4
Santa Cruz	4
Shasta	1
Siskiyou	1
Solano	1
Sonoma	2
Stanislaus	1
Tehama	1
Tulare	1
Ventura	3
Yolo	1
Yuba-Sutter	1

DECEASED

During the year seventy-six members answered their last summons. Their names are recorded in the archives of the Association and are listed in the report of the Committee on History and Obituaries (see page 313). For a time we will grieve that they are dead. For a longer time we will rejoice that they lived.

COMMENT

County officers have been commendably diligent in their endeavors to secure the affiliation of eligible members. California stands fifth in the country in membership strength. The national average is 60 per cent eligible members. California's average is 49 per cent. By means of sustained activity the endeavor will be made to secure at least 60 per cent affiliation by the end of 1935.

A reported gain in numbers of 126 members is encouraging.

FINANCES

The following is the certified audit of the Association's financial resources, expenditures, and receipts:

January 17, 1935.

California Medical Association,
San Francisco, California.

We have made an examination of the balance sheets of California Medical Association, San Francisco, and Trustees Of The California Medical Association (a corporation), San Francisco, as at December 31, 1934, of the statements of income and surplus for the Association for the year ended that date and for the Corporation for the period May 27, 1934 to December 31, 1934. In connection therewith we examined

or tested accounting records of the Association and the Corporation, and obtained information and explanations from officers and employees; we have also made a general review of the accounting methods and of the operating and income accounts for the year, but we did not make a detailed audit of the transactions.

Balance sheets setting forth in greater detail the assets and liabilities of the Association and the Corporation are included as a part of this report, our comments with respect thereto being as follows:

Cash on hand was counted at the commencement of our engagement and cash on deposit was verified by direct correspondence with the depositary banks and by reconcilement of the amounts so reported with the balances shown by the books of the Association and the Corporation at December 31, 1934.

Accounts receivable of the Association for advertising space in CALIFORNIA AND WESTERN MEDICINE were proved as to total by trial balance of the individual accounts and analysis of date of charge. After discussion of the accounts with the Secretary, we have charged off as uncollectible accounts amounting to $1,801.25 and have provided reserves on the remaining accounts which are, in our opinion, ample to cover losses in the liquidation of such accounts reasonably to be anticipated.

Investments of the Corporation were fully accounted for by physical inspection with the exception of United States Treasury bond No. 29802-B, which had been loaned to California Medical Association for use as collateral on a loan of $5,000 made by Wells Fargo Bank and Union Trust Company. The bank confirmed the fact that they were holding such bond at December 31, 1934.

Permanent assets of the Association, consisting of furniture, fixtures and office equipment, are stated at book costs less depreciation and are without appraisal or inventory by us.

Provision has been made for all ascertained liabilities of the Association and the Corporation at December 31, 1934, as disclosed by the records examined and information obtained by us. Note payable to bank of the Association was verified by direct correspondence.

We are informed that there were no suits pending nor contingent liabilities existing at the date of the balance sheets.

Under the caption of "Morris Herzstein Bequest" is shown the unexpended balance of income received by the Association from a trust fund of $20,000 established by Morris Herzstein for the purpose of "suppression of quackery in the practice of medicine within the State of California." The status of this bequest is as follows:

Balance, December 31, 1933	$2,093.22
Income for the calendar year 1934	964.09
	$3,057.31
Expenditures for the calendar year 1934	1,307.30
Balance, December 31, 1934	$1,750.01

We corresponded with a number of the county medical societies in confirmation of funds remitted by them for dues of members, and accounted for advertising revenue of the JOURNAL for the month of December. We did not verify the accuracy of charges and credits passed between the Association division and the JOURNAL division of the Association. Certain major disbursements to committees were not supported by invoices or other detail, but appeared to have been approved by the Council.

In our opinion, based upon our examination, the accompanying balance sheets and related statements of income and surplus fairly present the position of the Association and the Corporation at December 31, 1934, and the results from operations for the Association for the year ended that date and for the Corporation for the period May 27, 1934, to December 31, 1934.

ERNST & ERNST,
Certified Public Accountants.

BALANCE SHEET
DECEMBER 31, 1934

ASSETS

Cash		
On hand	$ 27.12	
On deposit:		
Commercial accounts:		
Wells Fargo Bank & Union Trust Co.	1,369.90	
Bank of America N. T. & S. A.	1,009.90	
Savings accounts:		
Anglo California National Bank	882.03	
Wells Fargo bank & Union Trust Co.	338.47	
Security-First National Bank, Los Angeles	23.98	
		$3,651.40
Accounts Receivable		
Journal advertisers	$2,367.15	
Less allowance for doubtful	235.46	
		2,131.69
Other Assets		
Due from employee	$ 65.00	
Deposit	18.48	
		83.48
Permanent		
Furniture, fixtures and office equipment	$6,426.70	
Less allowance for depreciation	3,358.42	
		3,068.28
Deferred		
Rent paid in advance		274.00
		$9,208.85

LIABILITIES

Note Payable (Secured)		
To bank for money borrowed		$5,000.00
Accounts Payable		
Creditors	$ 200.94	
Accrued interest	19.48	
Customers' credit balances	12.50	
		232.92
Deferred Income		
Dues paid in advance	$ 750.00	
Space paid for in advance	275.00	
		1,025.00
Morris Herzstein Bequest		
Unexpended balance of income		1,750.01
Nominal		
Profit and Loss Surplus		
Balance, December 31, 1934		1,200.92
		$9,208.85

PROFIT AND LOSS SURPLUS
DECEMBER 31, 1934

Balance, December 31, 1933, as shown by books		$113,244.60
Charges		
Transfer of surplus to "Trustees of the California Medical Association"	$75,430.35	
Bad debts written off—applicable to prior years	1,433.75	
Reduction of post office deposit	56.52	
		76,920.62
Adjusted surplus, December 31, 1933		$ 36,323.98
Deduction		
Net loss from operations for the year ended December 31, 1934, as shown by statement of income and expense:		
Association Division	$29,780.80	
Journal Division	5,278.10	
Transfer of surplus to "Trustees of the California Medical Association"	64.16	
		35,123.06
Balance, December 31, 1934, as shown by this report		$ 1,200.92

INCOME AND EXPENSE—ASSOCIATION DIVISION

For the year ended December 31, 1934

Income		
Membership dues	$50,760.00	
Less allocated to Journal	10,232.00	
		$40,528.00
Exhibits at annual meeting		2,085.00
Gross income		$42,613.00
Expense		
Salaries	$14,024.65	
Committee appropriations and expense, Public Relations, etc.	35,189.18	
Legal expense	9,157.19	
Rent	2,520.50	
Annual meeting expense	2,492.96	
Publications and subscriptions	2,328,00	
Travel	1,640.81	
Office supplies and expense	1,610.99	
Delegates—American Medical Association convention	891.05	
Depreciation	642.67	
Telephone and telegraph	589.15	
Postage	516.53	
Commissions	187.50	
Miscellaneous	1,852.15	
		73,643.33
		$31,030.33
Other Income		
Interest earned	$ 647.96	
Miscellaneous	621.05	
	$ 1,269.01	
Less Other Deduction		
Interest paid	19.48	
		1,249.53
Loss—Association division		*$29,780.80*

INCOME AND EXPENSE—JOURNAL DIVISION

For the year ended December 31, 1934

Income		
Advertising		$22,446.00
Allocation of dues		10,232.00
Subscriptions		605.88
		$33,283.88
Expense		
Salaries	$ 7,506.60	
Production	22,309.45	
Commissions	3,923.03	
Distribution	2,114.04	
Rent	838.50	
Office supplies and expense	825.47	
Collection expense	172.43	
		37,689.52
		$ 4,405.64
Other Deduction		
Bad debts and provision for doubtful	$ 1,052.46	
Less Other Income		
Sale of Review Books	180.00	
		872.46
Loss—Journal division		*$ 5,278.10*

COMMENT

The marked depletion of the Association's net worth is accounted for by the following extraordinary expenses incurred during the year in addition to increased legal expenses:

Appropriation to:	
Committee of Five	$28,643.31
Election educational expenses Nos. 9 and 17	14,286.28
Total	$42,929.59
Loss on California and Western Medicine	5,278.10
Total	$48,207.69

The Auditing Committee has, with the Council's approval, instituted the following controls:

1. That the bank salary account be closed. That salaries for the office staff be paid from the Revolving Fund;

2. That a Petty Cash Fund of $50 be continued;

3. That the Revolving Fund be reduced to $750. That it be reconciled in the Cash-Journal Ledger each month. That expenditures through the Revolving Fund be limited to salaries and immediate disbursement requirements. That all disbursements, in so far as possible, be by means of the regular Association voucher;

4. That all purchases be made through a purchase order form signed by the Secretary under authority given by the Council;

5. That a monthly trial balance be filed in the Cash Journal. Said trial balance to show unexpended appropriation balances;

6. That the value of office furniture be written off and carried in reserve statements at $1. That an inventory be made and filed annually in the Council minutes;

7. That all control accounts be entered in the general ledger.

ASSOCIATION ACTIVITIES

These have been commented upon and reported in the Council minutes and published committee reports. They are cited at this time as a matter of record.

Committee of Five.—Its report was transmitted at the special meeting and to this session.

Initiatives Nos. 9 and 17.—A report of the Association's educational work was imparted in the minutes of the adjourned two hundred and twenty-ninth meeting of the Council held on November 10, 1934.

Exhibits at State Fairs.—The Department of Public Relations has transmitted a report thereon.

Postgraduate Opportunities.—This work is being extended and will be a prominent feature during the coming year. Further comment will be found in the Council's report.

Public Health Education.—By early fall, arrangements will have been made so that speakers will be available for lay organizations. It is purposed to send out teachers, not advocates, to impart the truths of scientific medicine to lay people.

Speakers' Bureau.—Speakers have been provided for a number of county meetings. This service will be enlarged during the coming year.

Ivy Exhibit.—This exhibit imparting animal's contributions to public health, exhibited in the Century of Progress, was secured and placed on exhibit in Sacramento during the legislative session.

SERA.—The Association's Advisory Committee to the SERA has persistently sought to secure authorization for a uniform State plan for medical care of those on relief. Unless one is familiar with the procedures in the SERA office, it is difficult to understand the difficulties encountered by the committee. Time after time we were on the verge of securing authorization. Then some new obstacle would be confronted necessitating reopening of the entire question. In December, 1934, an acceptable plan was agreed upon, but while it was being typed the State Administrator's office became vacated and no one had authority to sign the agreement. This vacancy continued until February, 1935. However, on March 22, 1935, a definite agreement was reached and is now being applied. The details have been imparted to every county society.

Field Activity.—Your Secretary has visited and attended meetings of the following county societies:

Riverside	Stanislaus
San Bernardino	Alameda
Yolo-Colusa-Glenn	Tehama
Napa	Orange
Los Angeles	Sonoma
Santa Barbara	Placer
Marin	San Joaquin
Yuba-Sutter	Santa Clara
San Luis Obispo	San Francisco
Sacramento	

Addresses have been made to county Auxiliaries, study clubs, and Y. W. C. A.'s in several counties.

It is purposed to visit every county as rapidly as possible. County officers are again reminded that the Association's headquarters office and personnel are at their service and will promptly respond to all requests for information. Our desire is to be of helpful assistance at all times to all members.

I desire to express a very genuine gratitude and appreciation for the kindly assistance that has been rendered and for the cordiality that has been accorded to me.

Frederick C. Warnshuis,
Secretary-Treasurer.

PROPOSED AMENDMENTS TO THE CONSTITUTION
ARTICLE XIII, SECTION 2*

Amend Article XIII by adding a new section to be numbered Section 2, reading as follows:

"Section 2. To further aid in carrying out the objects of the Association, the House of Delegates at any meeting at any regular or special session thereof may, by a two-thirds vote of the membership thereof present and acting, authorize, empower and direct the Council to cause the formation and organization of one or more corporations under the laws of the State of California with such incorporators, name, purposes, county where the principal office for the transaction of business is to be located, first directors, the total number of shares, the aggregate par value, if any, of all shares, classes of shares, par value of any shares having par value, statement of the provisions, privileges and restrictions granted or imposed upon the respective classes of shares, or if the corporation be formed without capital stock the authorized number and qualifications of its voting and other rights of each class of members and the liability of each and all classes, to dues or assessments, and with such further provisions in the articles of incorporation thereof and with such by-laws as the Council shall prescribe, fix and determine; and the House of Delegates at any meeting of any regular or special session thereof may, by a vote of two-thirds of the members thereof present and acting, authorize, empower and direct the Council to grant, assign, transfer, convey or deliver or cause to be granted, assigned, transferred, conveyed or delivered to any of such corporations upon the formation thereof or to applicants for health and accident or other insurance in or from any of said corporations at or prior to the formation thereof without any consideration therefor, such funds and property, real or personal, of this Association as the House of Delegates shall from time to time authorize or ratify."

* * *

ARTICLE XIV, SECTION 1

Amend by-laws by adding thereto a new chapter to be number XIV, Section 1, reading as follows:

"Corporations. To further aid in carrying out the objects of the Association, the House of Delegates at any meeting at any regular or special session thereof, may by a two-thirds vote of the membership thereof present and acting, authorize, empower and direct the Council to cause the formation and organization of one or more corporations under the laws of the State of California with such incorporators, name, purposes, county where the principal office for the transaction of business is to be located, first directors, the total number of shares, the aggregate par value, if any, of all shares, classes of shares, par value of any shares having par value, statement of the provisions, privileges and restrictions granted or imposed upon the respective classes of shares, or if the corporation be formed without capital stock, the authorized number and qualifications of its members, the different classes of members, if any, the property, voting and other rights of each class of members and the liability of each and all classes, to dues or assessments, and with such further provisions in the articles of incorporation thereof and with such by-laws as the Council shall prescribe, fix and determine; and the House of Delegates at any meeting of any regular or special session thereof may, by a vote of two-thirds of the members thereof present and acting, authorize, empower, and direct the Council to grant, assign, transfer, convey or deliver or cause to be granted, assigned, transferred, conveyed or delivered to any of such corporations upon the formation thereof or to applicants for health and accident or other insurance in or from any of said corporations at or prior to the formation thereof without any consideration therefor, such funds and property, real or personal, of this Association as the House of Delegates shall from time to time authorize or ratify."

* Editor's Note.—See footnote on page 284.

REPORT OF THE EDITOR

To the President and the House of Delegates:

The editor's report on papers received, printed, awaiting publication, and declined, is as follows:

(a) *Report on papers of the annual session at Riverside, April 30 to May 3, 1934:*

At last year's annual session a total of 141 papers were read before the general meetings and different sections. A summary of the disposition of the papers read at last year's annual session is as follows:

Riverside annual session papers published in 1934	39
Riverside annual session papers published in 1935	16
Riverside annual session papers read, but published elsewhere, declined, or not sent in	66
Riverside annual session papers in CALIFORNIA AND WESTERN MEDICINE files still awaiting publication (annual session papers in this April issue still to be deducted)	20
Total annual session papers read at Riverside	141

(b) *Report on all special articles which have been printed in* CALIFORNIA AND WESTERN MEDICINE *during the period April, 1934 to April, 1935 inclusive:*

Special and original articles which were published in CALIFORNIA AND WESTERN MEDICINE during the past year (April, 1934 to April 1935, inclusive) are as follows:

Section papers from annual session at Del Monte, 1933	9
Section papers from annual session at Riverside, 1934	50
Papers read before general session at Riverside	5
Lure of Medical History articles	12
Papers from Nevada State Medical Association meetings	1
Papers read before county and other medical societies	5
Papers accepted from miscellaneous sources (original articles, abstracts of speeches, reprints from other publications, etc.)	31
Clinical Notes and Case Reports	38
Editorials	55
Editorial Comment articles	39
Bedside Medicine symposia	12
Total papers published during past year	257

(c) *Report on manuscripts in* CALIFORNIA AND WESTERN MEDICINE *files and awaiting publication in issues of April, 1935, and later:*

Unpublished papers from annual session at Riverside, 1934	20
Unpublished papers from Nevada State Medical Association meetings	2
Unpublished papers read before county and other societies	5
Unpublished papers not read before other societies	12
Lure of Medical History articles	4
Clinical Notes and Case Reports	18
Editorial Comment articles	6
Bedside Medicine symposia	3
Total manuscripts on hand awaiting publication	70

(d) *Report on non-annual session papers submitted:*

A total of forty-three papers from county societies and other sources which were submitted for publication in CALIFORNIA AND WESTERN MEDICINE during this past fiscal year (April, 1934 to April, 1935 inclusive) could not be accepted for various and special reasons.

Non-annual session papers submitted, but declined	43

CALIFORNIA AND WESTERN MEDICINE is the expression in publication of the California Medical Association, one of the larger state units of organized medicine. While it is true that our State Association subscribes in fullest measures to the highest standards of scientific medicine, our organization has primarily to do with organized medicine, and its official publication, while designed to promote scientific medicine, cannot afford to do so at the expense of organized medicine. A large number of purely scientific publications furnish a means through which articles on scientific or technical subjects, having only moderate lure for general practitioners, may have an opportunity of reaching physicians who are particularly interested in the topics discussed.

Dilemmas which constantly face the editorial management of your official journal are due to the fact that the California Medical Association is one of the large state medical societies in our country, that its annual sessions bring to it more papers than could be printed even if the size of CALIFORNIA AND WESTERN

MEDICINE were doubled, and that in a publication appearing only once a month and of limited size, it takes from twelve to fifteen issues to place in print those annual session and county society papers that have been accepted. It is regrettable, as has been stated in previous reports, that these exigencies make it impossible to expedite the publication of papers faster than they now appear. In this connection it is proper to keep in mind, also, that of the five thousand members of the California Medical Association, only about five hundred are specialists, although a much larger proportion of the papers submitted come from the pens of specialists. Even though many such articles possess special merit, it may not be possible to accept them, because they are ofttimes of only casual interest to members of the Association who are in general practice, but who, by their number not only furnish a considerably larger proportion of the financial support of the official publication, but become important factors, because of the places they occupy in both professional and civil life, in what is known as organized medicine, of which in our State the California Medical Association is the dominating expression. So, also, as regards the publication in single issues, of papers from only one section, whether as parts of symposia or otherwise: it must not be forgotten that while that method of publication might be pleasing to the members of such a section, it might be quite otherwise with a much larger number of members of the Association who, having no particular liking for the presentations, would regret the absence of articles on other subjects that might be of greater help or interest to them. These various basic policies are discussed in a small brochure having the title "Suggestions to Authors," copies of which are sent to authors of papers and other members who apply.

An effort to present different or even opposing phases of subjects having to do with scientific and organized medicine is constantly made, because interest is ofttimes better awakened in that manner than if the information printed is all of the same nature. Members who disagree with viewpoints presented by authors are invited to submit letters or articles for possible use in the Correspondence or other departments.

In previous years, in this report it has been customary to make some brief comments concerning the financial status of the official journal. The continuation of the general economic depression in the United States has meant a corresponding diminution in the income derived from our advertising pages. The Council, however, in spite of the lesser receipts, has maintained the size of the official publication even though, by so doing, a certain bookkeeping loss is unavoidable. Earnest efforts are being made to increase the advertising income, and suggestions for possible business contacts will be welcomed.

In conclusion, your editor wishes again to thank the many members who have contributed so generously in making it possible for CALIFORNIA AND WESTERN MEDICINE, as the official publication of the California Medical Association, to represent it in commendable printed expression.

Respectfully submitted,

George H. Kress, *Editor.*

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

San Diego, Riverside, Orange, and Imperial Counties

To the President and the House of Delegates:

Your Councilor has visited all the county units in the district, from time to time, except the San Diego unit. Councilor-at-Large Tanner has represented the Council in contacting that unit. All the units in this district are in satisfactory condition, both as to membership and interest.

Medical economics have occupied the interest of these groups to a greater degree than ever before. The San Diego Society has been actively interested in the development of a group-insurance plan, which gives promise of successful conclusion. The San Bernardino Society has worked out, and has in active operation the most successful agreement for the SERA workers and their families that has come to my attention. This includes office, home, and private hospital care on a fee basis. The Riverside Society has a similar arrangement, except that hospitalization is at the County Hospital. Orange County has a similar arrangement.

Delay in establishing a state-wide program for these workers and their dependents has seemed to be unavoidable. These county units which have worked out a fairly satisfactory solution of the problem are to be commended.

The scientific programs of the county societies have been well handled. In addition to the monthly programs a district committee has been formed which includes Riverside, San Bernardino, and Orange counties, for the purpose of conducting postgraduate clinical meetings, as recommended and sponsored by the California Medical Association. These meetings should be helpful, as postgraduate instruction has been more limited than heretofore because of economic conditions which have affected all our incomes.

The most effective method of combating cults and adverse criticisms is for the medical profession to furnish more efficient service to the public. The best service cannot be furnished unless we continue our education in every way possible. The county units in our district are unanimous in commending the California Medical Association for offering the postgraduate study program.

Respectfully submitted,

W. W. Roblee, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

A review of the past year in medicine in Los Angeles County is very encouraging, granting that our problems appear, and do each day grow more serious and more difficult of solution.

The organized medical profession in Los Angeles is becoming recognized as an important part of the social fabric. It is being consulted on issues that may affect the social scheme, and is accepting this recognition and meeting it with that spirit of coöperation that is so essential if medicine is to retain its place.

The Los Angeles County Medical Association has worked unremittingly with the local committees, seeking to provide medical care for the unemployed. At innumerable committee meetings medicine has been represented, seeking with these committees to develop a program that would best serve the public and preserve medicine as a profession; impressing upon them the importance to the public of the maintenance of our professional status.

Since the appointment of a medical director for the Los Angeles County Relief Administration the same coöperation on the part of organized medicine has been offered and accepted by him. The medical panel was created by the Medical Association. The Medical Advisory Committees for the twenty-odd unemployment districts were appointed by the Association. The program for telephone communication throughout the county and the managing of emergency calls under this program of medical care was developed by the Association.

Non-member physicians throughout the county are beginning to become aware of the activities of the County Medical Association and to realize its value and their need of it. This is shown through the increase in membership, 188 new members being recorded for the year, many of these joining in the past few months. Only four members resigned during the year, and, considering the depression, the number who were dropped for non-payment of dues was extremely small.

Since the completion and occupancy of our library and headquarters building we have had a definite nucleus of medical activities and fellowship which has been productive of far-reaching results. A greater spirit of coöperation among the members is apparent and there has been an awakened interest and a clearer understanding of financial, economic, and political activities on the part of the membership as a whole. Since the opening of these buildings early in October, 1934, one hundred and thirty-six meetings have been held there, with a total attendance of 9,600. Not the least of the beneficial results have been due to the lunch-room facilities, which have been taken advantage of in some 7,800 visits by members and friends. These contacts cannot but result in a deeper understanding and a more steady interest in the problems of medicine, with a richer benefit to all concerned.

Respectfully submitted,

Carl R. Howson, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Bernardino, San Luis Obispo, Santa Barbara, and Ventura Counties

To the President and the House of Delegates:

Increasing interest in medical economics is being shown by all the component societies and, instead of referring all such problems to committees alone for solution, the entire membership attending a meeting takes an active interest and discusses at length the questions before it. Not infrequently an entire program will consist of addresses on and discussions of economic problems, state-wide as well as local, although local problems in all the counties are pressing and require as early solutions as possible. In every meeting attended by your councilor, pertinent questions regarding both hospital and health insurance were asked; but, unfortunately, most of them are as yet unanswerable. Your secretary, Doctor Warnshuis, has already, in spite of the press of your Association's business, addressed meetings of the Santa Barbara and San Luis Obispo societies on these subjects, and we are assured that the other counties will be visited as soon as his schedule will permit. All this shows a healthy interest and a marked contrast to the situation of a few years ago. If the individual members of the component societies continue to show this active interest, we may feel safe for the future, as there will be no question but that these problems will all be met and eventually solved.

No report will be made on the hospital situation in Kern County, as this will be covered in the report of the legal department. I can only repeat what I said in last year's report: that if all component societies would face their local problems with the energy and courage shown by our colleagues in Kern, we would soon be freed of many of our difficulties.

The inauguration of the "Community Clinic Service" by the Santa Barbara Society is of especial interest. A trained social worker, who is also a graduate nurse, has been given an office in a downtown building. Any person who needs medical or hospital care and cannot pay the prevailing fees, may go to this office and, after investigation, receives a rating card which, by a key-figure, shows the doctor or hospital his net income. If this is less than $50 a month, he is referred to the County Clinic, which accepts this rating. A fee schedule for the different ratings has been set up, and the members of the Society have agreed not to exceed this schedule. All fees are alike in that no provision is made for an increase for specialist's work. Many physicians refer their patients in the low-income group for a rating before setting their fee for their services. The hospitals are also giving reduced rates on these schedules, and a number of druggists have joined in reducing their prices on prescriptions according to these ratings.

Anyone wishing details of this plan may obtain them from the chairman of the Economics Committee, Dr. P. A. Gray, Jr., 317 West Pueblo Street, Santa Barbara.

Respectfully submitted,

H. J. Ullmann, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT*

Calaveras, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties

To the President and the House of Delegates:

I herewith submit the following report as councilor of the Fourth District.

With the exception of Fresno County, each society in the district was visited at a regular meeting. A meeting was held at Fresno with the secretary and delegates of that society. All of the societies in the district are active, hold regular meetings, and are greatly interested in health insurance.

Those societies that depend on outside speakers for their scientific programs express the thought that there could be an improvement in the extension lecture service.

In the Fourth District, membership is on a par with the general proportionate membership throughout the State; yet each society in the district has an active Membership Committee, and is endeavoring to have every eligible licentiate affiliate with the organized groups.

Respectfully submitted,

Fred R. DeLappe, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

I wish to report that during the past year I have visited at least one meeting of each of the five county societies in the Fifth Councilor District, with the exception of San Benito County, where a meeting could not be arranged.

Respectfully submitted,

A. L. Phillips, *Councilor,*
Fifth District.

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

The year 1934 has been a very encouraging one in this district. After several years of study, discussion and argument, we find a greater unanimity of opinion on matters of economic medicine than ever before. The San Francisco County Society is at a point from which we may look into the future with more hope of success than ever before in solving our mutual problems.

We are fortunate in having for president Dr. J. C. Geiger, Director of Public Health, whose loyalty to the profession, his directing ability, and his unusual knowledge and experience in political matters are of great advantage to us.

We are looking forward to our most successful year from the Association's standpoint.

Respectfully submitted,

Karl L. Schaupp, *Councilor,*
Sixth District.

* Councilor De Lappe submitted his resignation as a member of the Council on March 3, 1935.

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

Regular meetings have been held in both Contra Costa and Alameda counties. Aside from the usual scientific programs, the most important activity has been the study of the problem of medical economics.

The plan used in Alameda County contemplates for its general purpose the medical care of all persons who live in Alameda County on the basis of ability to pay. The detail of this plan requires that medical care and hospital care for indigents at home, out-patient relief, or in the hospital, shall be supplied at the expense of Alameda County.

There are a number of persons in the middle class who are able to pay in part for professional services. The organized medical profession have agreed, through the County Medical Society, to take care of these patients on a part-pay basis, or a basis of less than normal fees. This part-pay program has been operating for approximately two and one-half years and was organized by mutual agreement between the Alameda County Medical Association and the Alameda County Institutions Commission. It provides that patients unable to pay full fees, but who are not indigent, are referred to members of the County Medical Society in rotation for such care as they require.

During 1933 more than two thousand cases were so referred by the Social Service Department of the County Institutions to physicians willing to accept patients on this basis. These referred patients paid to private physicians a sum slightly in excess of $5,000. While statistics for 1934 are not complete, the monthly reports indicate that a larger number of persons than previously have been referred to private physicians, and that fees collected have been in excess of those collected in 1933.

For the prevention of disease, the plan used in Alameda County contemplates a county health department operated under the same general supervision as are other county institutions. This permits a program of prevention to be carried on under unified direction in full coöperation with the County Medical Association. The Board of Supervisors many years ago placed the operation of the county institutions, designed for the care of indigent poor, under a citizens' committee known as the County Institutions Commission. This Commission, by arrangement with the Board of Supervisors, about two and one-half years ago took over all medical activities in Alameda County for which taxes are used for payment, including the operation of the county hospitals and county clinics, and the work of county physicians and the County Health Department. The combination of all of these activities, in full coöperation with the medical society and all volunteer agencies engaged in public health work here, preventive or curative, operates in unity for the purpose of carrying out the program as used in Alameda County.

Respectfully submitted,

Oliver D. Hamlin, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

The councilor of the Eighth District has attended all meetings of the Council at Riverside during the past session of the California Medical Association, and has attended all meetings of the Council during sessions held at San Francisco in the past year, with the exception of meetings which dealt directly with matters pertaining to the penalization of certain members of the Association; excusing himself on the ground of being also a member of the State Board of Medical Examiners, when the possibility of dual hearings and dual opinions made it inadvisable to be in attendance.

The necessary correspondence with the secretaries of various county societies in this district has been attended to, and such advice and suggestions have been given to various societies in this district when called upon to do so. He has attended several meetings of the Placer County Society and has visited five other societies in the district during the year and discussed pertinent subjects with the members of the societies.

There have been, apparently, no difficulties of any magnitude arising in any of the societies in this district rendering it necessary to bring to the attention of the Council, and such problems as have arisen he has been able to satisfactorily solve.

Respectfully submitted,

Charles E. Schoff, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

A brief report of the medical societies' activities in the Ninth Councilor District during the year 1934 is submitted:

During the past year we have made councilor visits to all county medical societies, with the exception of Siskiyou County. To those societies close enough that the visits require only one day's travel, we have made repeated visits in order to inform them of the work of the Council and the work of the Committee of Five.

It has been very gratifying to notice the increasing interest taken in the activities of the State Society and the Council, and in medical economics.

In the counties composing the north bay section, the members of the various societies are visiting the adjoining county society meetings, so that our medical meetings are very interesting and have a large attendance.

President Dr. Clarence Toland, Dr. Edward Pallette and Dr. J. B. Harris were the guests and speakers at a joint meeting of the Napa County Society. This was a most interesting meeting. Those who wished, played golf during the afternoon, and this was followed by an excellent dinner and the business of the evening.

During this year your councilor has attended all meetings of the Council, and the special session of the House of Delegates at Los Angeles.

Respectfully submitted,

Henry S. Rogers, *Councilor,*
Ninth District.

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

In many ways this year has been a critical one for the California Medical Association. The Council has had an unusually strenuous twelve-month, being compelled to carry an ever increasing responsibility for the future and welfare of the profession. It has been particularly timely and necessary that the House of Delegates share this responsibility. I am very grateful for the special session at Los Angeles to direct the action of the Council.

The San Diego County Medical Society also has faced a critical year in the problems of the County Hospital and County Welfare. Local political changes at the November election have threatened to undo all the work that the Society has done in the past ten years. There has been a vigorous effort to split the membership in these problems of public policy, and thereby destroy the influence of the Society. The Society, therefore, is to be congratulated on presenting a united front, and in loyally supporting the Council and the committees charged with these activities.

The year has developed a new and forceful coöperation between the medical and dental societies in San

Diego. The combined effort in the Public Health League at the primary and general elections has created a new mutual understanding and mutual interests that will benefit the public and both professions. The councilor-at-large from this section has necessarily been involved in all of these activities, which have a state-wide as well as local significance. He has attempted to represent the California Medical Association in all of these local problems.

Respectfully submitted,

C. O. Tanner, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your councilors-at-large, and in conjunction with the undersigned's work as chairman of the Committee on Public Policy and Legislation, it has been possible for him, during the last year, to make visits to a goodly number of the component county societies of the California Medical Association.

He is deeply impressed with the interest which members of the profession, from one end of the State to the other, are taking in matters having to do not only with scienific medicine, but with economic phases of the practice of medicine. This increased coöperation on the part of many physicians who formerly only took a casual interest in the work of organized medicine should be reassuring to all of us and may be construed as an indication of successful results.

Respectfully submitted,

Junius B. Harris, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year we have contacted a number of the different county units. It is gratifying to see the interest which the members are taking in organized medicine, and what it stands for and is trying to accomplish. At the recent special meeting of the House of Delegates, the attendance was an evidence of the great interest the members have in their profession, as was also the open and free discussion of this subject that is of such vital importance to all physicians.

It seems to me that the members are more alert than ever before to their responsibilities regarding public health, and their position in the economic scheme of things.

Respectfully submitted,

W. H. Kiger, *Councilor-at-Large.*

To the President and the House of Delegates:

This particular councilor-at-large has devoted his time in discharging the duties assigned to him as chairman of the Council and as a member of a goodly number of special committees.

The problems that faced the profession and the Association have been many. Each had a vital bearing upon our future. Each required study and detailed consideration in order that the best interests of the Association might be enhanced. An extraordinary amount of time was required by these activities.

It is the opinion of this councilor that it is necessary for the Association to use every effort and resource to aid in the development and control of changes affecting medicine and the profession that may be proposed or that may occur.

Respectfully submitted,

T. Henshaw Kelly, *Councilor-at-Large.*

To the President and the House of Delegates:

Observation shows a marked increase, on the part of the membership of California Medical Association, of interest in and knowledge of the important matters now confronting the medical profession.

The activities of the secretary are of great value in welding the California Medical Association into a homogeneous organization.

It will still remain for the membership to respond without delay to demands for action by those to whom we entrust our destinies.

Every opportunity is being seized to inform the membership on important points, and to emphasize the need for united action, without delay, on demand.

Respectfully submitted,

M. R. Gibbons, *Councilor-at-Large.*

REPORTS OF STANDING COMMITTEES*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

William W. Roblee, Chairman, 1937

Clifford Sweet, 1935 William H. Geistweit, 1936

The Committee on Associated Societies and Technical Groups has been rather inactive during the past year.

The chairman has had occasional conferences with the president of the Woman's Auxiliary, at which some of their problems have been discussed.

The special committee appointed to conduct a survey of medical economics in this State has had close contact and coöperation with the dental association; otherwise our Association has had no need for special association with them. The committee has been ready at all times to confer with associated groups if the need should arise.

Respectfully submitted,

W. W. Roblee, *Chairman.*

COMMITTEE ON EXTENSION LECTURES

Executive Group

Robert T. Legge, Chairman, 1937

James F. Churchill, 1935 J. Homer Woolsey, 1936

The Secretary, ex officio

To the President and the House of Delegates:

The chairman of the Committee on Extension Lectures respectfully submits for your consideration the following report for the year 1934.

For several years your committee has prepared for the various county units a selected list of speakers, consisting of specialists and research workers in the field of medical science, who were prepared, upon invitation, to deliver papers on special subjects. The committee felt that, while this type of extension service was worth while, it did not fulfill the great need of the various county societies in our large State. The profession is well provided for in our large cities by the teaching and hospital centers, and they have entrée to the interesting hospital staff meetings. This, however, is not the case in the rural counties. One of the major efforts of the California Medical Association should be to promote, through the Extension Committee, the highest type of postgraduate service to these counties. This will have a tendency to bring to the profession in their own home towns the newer developments in medicine and surgery, presented by the foremost men from the teaching institutions and medical centers of our large cities. It is needless to state that it will promote better medicine in our smaller towns, and its value to public health and medical science can readily be estimated. Your committee feels that it is a big step in the right direction for our Society to devote to our rural county units such an extension service, and to provide the necessary funds to defray traveling expenses and limited hotel accommodations for the group or team which provides the lectures and clinic demonstrations.

* Members of Standing Committees are urged to meet during the annual session and organize for the coming year, and to hold at least one regular meeting of their respective committee during the annual session.

It is suggested that such extension service be provided in each councilor district of our State. A session would consist of six to twelve meetings annually, given fortnightly, preferably on a Friday evening, according to a prescribed program, in a town where a hospital is located.

Through the efforts of Dean R. Langley Porter and Dr. W. E. Carter of the University of California Medical School, there has already been established, during the past two years, in six districts in northern California, namely, Eureka, Chico, Santa Rosa, Sacramento, San Jose and Fresno, a postgraduate service. On the request of committees of local physicians, these sessions have been developed successfully, and have been enthusiastically received by the profession; the sponsors simply contributing a small sum to cover the actual expenses of traveling and clerical services. Some thirty-six subjects and eight symposia on important medical subjects are in preparation for future sessions.

The University of California Medical School is to be congratulated on this pioneer venture. Their interest and their willingness to coöperate with the Extension Committee of the State Medical Society in every way is greatly appreciated.

During the year your chairman, Dr. R. T. Legge, called two meetings—one in San Francisco and one in Los Angeles. At the San Francisco conference, Doctors Langley Porter, W. E. Carter, F. C. Warnshuis, and R. T. Legge were present. Unfortunately Dean Chandler of Stanford was absent. Plans were suggested and means offered to establish in the councilor districts postgraduate sessions under the auspices of the State Society, and to secure the coöperation of the medical schools and hospital centers for developing teaching and lecture groups, composed of outstanding members in the fields of medical science.

Present at the Los Angeles conference were: Dean McKibben and Dean Newton Evans of the two Class A medical schools; President Toland, Editor George H. Kress, Secretary F. C. Warnshuis, and Doctors Churchill and Legge of the Extension Lecture Committee. At this meeting the proposed postgraduate sessions to be offered in Southern California were enthusiastically received. The deans of the medical schools, representing the University of Southern California and the Medical Evangelists, pledged their willingness to coöperate with the State Society in developing this important educational service south of the Tehachapi. Dr. J. H. Churchill of San Diego, a member of the Extension Committee, is to call a meeting from time to time to get the sessions established, and is to report to Secretary Warnshuis' office. President Toland and Dr. George H. Kress were intensely interested in the progress that has been made, and believe this service will meet a long-felt want of the profession in the State.

The Extension Committee recommends that a budget be awarded annually to provide sufficient funds to defray the actual traveling expenses of the clinicians, and the secretarial work necessary to conduct the sessions. We look to the faculties of the four medical schools in California, and to such specialists and members of hospital staffs as may be willing and able to contribute their skill and time.

We further believe that if the State Society agrees with our recommendation and can coördinate, organize and encourage this activity, the real value of scientific and up-to-date medicine can be so demonstrated that the inferior medical service of the cultists—to whom so many persons now turn—will lose any appeal it may have for the public, and that we will be able to help establish scientific medicine without any important rivals in California.

It is hoped that the House of Delegates at this session will give this matter close consideration and coöperate in the splendid work that has already been established by Dean Porter and his associates. The University of California and Stanford University medical schools, with the aid of the leading hospital centers, have professional facilities to take care of the northern California districts, and are willing to coöperate in this fine work; likewise the two Class A medical schools in the southern part of the State.

It is recommended that the present committee be enlarged to include the Secretary of the Association, also Dr. W. E. Carter, director of the out-patient department of the University of California Hospital, San Francisco, and Doctor Toland or Doctor Kress of Los Angeles.

The activities of the Committee on Extension Lectures will appear, from time to time, on a special page of California and Western Medicine.

Respectfully submitted,

Robert T. Legge, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

Fred B. Clarke, Chairman, 1935

W. R. P. Clark, 1936 Benjamin W. Black, 1937

To the President and the House of Delegates:

The report of the Committee on Health and Public Instruction for the year 1934 is as follows:

The suggestions made last year and the year before are still under consideration by the Department of Public Relations.

Respectfully submitted,

Fred B. Clarke, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

George D. Lyman, Chairman, 1937

Charles D. Ball, 1935 J. Marion Read, 1936

The Secretary, ex officio The Editor, ex officio

To the President and the House of Delegates:

I greatly regret to notify the House of Delegates that the committee, of which I had the honor to be the chairman, did not hold any meetings last year.

It is hoped that during the coming year it may be possible for the members to outline a plan for gathering historical material and preparing the same for future publication.

Following the custom of previous years, the names of members who died during the last year are appended hereto.

IN MEMORIAM

Anderson, Louis Nels, September 6, 1934, Inglewood.
Arthur, Samuel Richard, November 25, 1934, Sacramento.
Ashmore, Frank, April 30, 1934, Santa Ana.
Bacon, David N., February 12, 1934, Bakersfield.
Bates, Walter Ernest, February 2, 1934, Davis. (Retired member.)
Bell, Harry D., August 4, 1934, Oakland.
Bell, Leo Pecci, October 4, 1934, Sacramento.
Biggs, Elmer LeRoy, May 6, 1934, Los Angeles.
Bucher, William Henry, December 30, 1934, Olive View.
Clarke, Louise Harvey, August 27, 1934, Riverside.
Clymer, H. Vance, October 4, 1934, Fairfield.
Congdon, Willis Rollin, August 18, 1934, Santa Cruz.
Conrad, Alexander H., May 10, 1934, Perris.
Dannenbaum, Sydney Ray, December 23, 1934, San Francisco.
Dillon, G. Parker, July 18, 1934, Sacramento.
Donnell, Robert Harold, January 26, 1934, San Diego.
Eaton, George Lee, April 25, 1934, San Francisco.
Elliott, Addison Eugene, April 9, 1934, San Diego.
Ford, Campbell, February 11, 1934, San Francisco.
Francis, Loftus H., July 27, 1934, Cotati. (Retired member.)
Franklin, John Henry, April 23, 1934, Guadalupe.
Fry, Philip Benjamin, August 21, 1934, Benecia.
Glaser, Edward Frederic, May 9, 1934, San Francisco.
Gray, Allen Earl, March 16, 1934, Marysville.
Hall, John Howard, July 2, 1934, Sacramento.
Harding-Mason, John, December 13, 1934, San Francisco.
Hart, Trusten Mitchell, July 14, 1934, Los Angeles.

Hennemuth, John L., December 9, 1934, Modesto. (Retired member.)
Hildreth, Herman Lee, March 7, 1934, Julian.
Holmes, Thomas Blakeney, May 12, 1934, East Oakland.
Ishikawa, Eisuke, November 28, 1934, Stockton.
Johansen, Erneste A., September 8, 1934, San Francisco.
Johnson, Llewellyn R., May 26, 1934, Stockton.
Kellogg, Llewellyn C., September 1, 1934, Loma Linda.
Klutho, John Cornelius, March 16, 1934, Los Angeles.
Kuser, John Henry, August 27, 1934, San Rafael.
Kylberg, Hjalmar, December 30, 1934, Merced.
Lamkin, Burt B., October 22, 1934, Fresno.
Lawhead, H. Davis, November 29, 1934, Woodland. (Retired member.)
Leech, Claude Reznor, January 13, 1934, Walnut Creek.
Lockwood, Sheridan A., May 29, 1934, National City.
Luttrell, Peter Harrison, December 17, 1934, San Francisco.
McCarty, Isaac A., March 23, 1934, Los Angeles.
McKay, Emma E., July 9, 1934, Hollister.
McKay, William T., June 12, 1934, Long Beach.
McLaren, Jay L., January 23, 1934, Bell.
McMullin, Smith, August 9, 1934, Yuba City.
Montgomery, Alexander B., March 11, 1934, Long Beach.
Neighbors, Clarence Anson, November 14, 1934, Anaheim.
Oatman, Homer Clifton, Jr., June 16, 1934, San Diego.
Phillips, Percy Todd, October 29, 1934, Santa Cruz.
Reinstein, Arthur Henry, August 17, 1934, San Francisco.
Reynolds, Ralph W., April 19, 1934, Pasadena.
Richards, Robert Lewis, May 26, 1934, Santa Barbara.
Robertson, Herbert Miller, June 1, 1934, Santa Ana.
Roe, Jesse Nathaniel, August 4, 1934, Riverside.
Ryfkogel, Henry A. L., June 11, 1934, San Francisco.
Sampson, Arthur F., November 27, 1934, San Francisco. (Retired member.)
Scudder, John Hedley, January 25, 1934, Oakland.
Sexton, Charles L., August 23, 1934, Los Angeles.
Seymour, James H., August 13, 1934, Los Angeles.
Simmons, Samuel Ewer, November 21, 1934, Berkeley. (Retired member.)
Smith, Arthur Clarkson, November 25, 1934, Oakland.
Stiles, William H., March 25, 1934, San Bernardino. (Retired member.)
Stillman, Stanley, October 15, 1934, San Francisco. (Honorary member.)
Strong, David Charles, September 10, 1934, Upper Lake.
Swisher, James Riley, January 31, 1934, Healdsburg. (Retired member.)
Tilton, Albert L., August 31, 1934, Los Angeles.
Utley, Jay H., July 12, 1934, Beverly Hills. (Honorary member.)
Van Metre, Harold, January 27, 1934, Los Angeles.
Wagner, Carl R., June 8, 1934, Pasadena.
Wallace, Edward Lee Roy, June 7, 1934, Los Angeles.
Watkins, James Thomas, February 18, 1934, San Francisco.
Warwick, Charles Spurgeon, January 27, 1934, Santa Barbara.
Young, Philip G., September 18, 1934, Sacramento.
Ziegelman, Edward F., October 12, 1934, San Francisco.

Respectfully submitted,

George D. Lyman, *Chairman.*

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Executive Group

Daniel Crosby, Chairman, 1935

John C. Ruddock, 1936 Karl L. Schaupp, 1937

To the President and the House of Delegates:

In response to Secretary Warnshuis' letter of January 8, may I say that, as chairman of the Committee on Hospitals, Dispensaries and Clinics, nothing whatever has come to my attention in the year past, and I have nothing of special importance to report.

Respectfully submitted,

Daniel Crosby, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Morton R. Gibbons, Chairman, 1935

Mott H. Arnold, 1936 Harry E. Zaiser, 1937

To the President and the House of Delegates:

The recent announcement that fees for industrial accident surgery would be cut, if permission could be obtained from the Industrial Accident Commission, was taken up with the Commission by this committee and delay secured.

Resolution of the Council of the California Medical Association of March 1, 1935, provides for a review of the fee schedule and circumstances concerning abuse of the schedule, and contemplates recommendations for corrections. Report of study and recommendations will be made to the Council at the annual session.

Respectfully submitted,

Morton R. Gibbons, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

Loren R. Chandler, Chairman, 1936

George Dock, 1936 John B. Doyle, 1937

To the President and the House of Delegates:

The Committee on Medical Education and Medical Institutions has held no meetings this year. The activities of the four medical schools in California are well known, and have been described adequately in previous bulletins and reports.

This committee urges the California Medical Association to coöperate with the medical schools in California in developing and furthering postgraduate medical education in these schools.

Respectfully submitted,

L. R. Chandler, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

George G. Reinle, Chairman, 1935

Fred R. DeLappe, 1936 John P. Nuttall, 1937

To the President and the House of Delegates:

Your committee desires to report for the year 1934-1935 that nothing has been referred for its consideration.

But from year to year the membership of the "Medical Society of the State of California" (not one and the same as the "California Medical Association") has been decreasing, until at the present time there are but 378 members, from a one-time maximum of over 750.

It is the understanding of the committee that a resolution was at one time passed that the "Medical Society of the State of California" should in no way publish nor endeavor to increase its membership by any method of publicity among the members of the California Medical Association. It is quite obvious that without such publicity its members are not aware of the important services which will be rendered them. For instance, that the members of the "Medical Society of the State of California" are represented by the legal counsel of the California Medical Association, with his tremendous experience and background and/or by an attorney appointed by him, in conjunction with the attorney of the company in which they are insured, who determine what is best in the premises. It is important that California Medical Association members should know this, particularly at this time when several insurance companies are withdrawing entirely from the field of insuring physicians and surgeons, or are limiting their coverage. The conditions now existing are very unsatisfactory—the number of suits continue to increase, while the insurance companies who do write such policies are raising their rates.

It is understood that a special committee of the Council has been appointed to consider the feasibility of organizing an indemnity exchange. This is a form of insurance authorized by law, and by combining the funds of the old "Indemnity Defense Fund" with the funds of the "Medical Society of the State of California," with a small initial enrollment and assessment of, say 750, interested men, it is believed that a very

satisfactory plan can be developed entirely new from any plan heretofore considered. The proposed "Exchange" would only issue a small coverage, say $1,000 and $3,000, but it would by contract with a large company issue any size policy desired, the "Exchange" taking only the amount indicated.

Your committee recommend to the House of Delegates that the above-mentioned special committee continue to study the feasibility of organizing such an indemnity exchange and formulate such plans as may be necessary. If that is not done, then other methods should be devised to increase the membership of the "Medical Society of the State of California."

Respectfully submitted,

George G. Reinle, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

John H. Graves, Chairman, 1935

William R. Molony, Sr., 1936 Willard J. Stone, 1937

To the President and the House of Delegates:

The committee has not conducted any independent investigation this year in regard to the economic status of doctors of medicine because the attention of the Society has been focused on constructive insurance plans. The members, however, have contacted several of the county medical societies, and the Southwest Pediatrics Society, presenting to them the progress that is being made in California toward the more adequate distribution of medical care.

The activities of the Committee on Medical Economics are so merged with the Public Relations Committee that a separate report is unnecessary.

Respectfully submitted,

John H. Graves, *Chairman.*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

Harry H. Wilson, Chairman, 1935

Dewey R. Powell, 1936 Thomas H. McGavack, 1937

The Secretary, ex officio

To the President and the House of Delegates:

There have been no meetings of the committee. The attention of the members has been directed toward activities associated with the Board of Councilors and the Public Relations Committee in bettering the conditions of the profession generally, with the belief that this type of activity would result in attracting a greater membership to the California Medical Association.

Respectfully submitted,

Harry H. Wilson, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Junius B. Harris, Chairman, 1935

Fred R. DeLappe, 1936 E. T. Remmen, 1937

The President, ex officio The President-elect, ex officio

To the President and the House of Delegates:

The California Legislature being in session, it follows that the Committee on Public Policy and Legislation has before it its usual extensive array of proposed laws having a bearing on the public health and on medical practice. A partial list of the bills submitted was printed on pages 229-231 of the March, 1935, number of California and Western Medicine.

Your committee has studied the 3,677 bills now before the legislature and finds 168 that have some bearing upon questions of public health. An unusual situation prevails this year in the large number of skeleton bills introduced to hold positions on the calendar. There are 540 skeleton bills in the Assembly and a proportionate number in the Senate. It is necessary to watch these carefully, as many of them can easily be filled in with subject-matter relating to public health legislation.

During the legislative recess, meetings were held in San Francisco and Los Angeles with members of the Council, committeemen, officers and committees of the Public Health League of California and allied groups, at which your chairman brought to their attention some of the measures most vitally affecting medical practice and public health. Much constructive assistance came out of these meetings.

Your chairman is greatly impressed at this session of the legislature by the average high type of legislator selected by the voters to represent them at Sacramento. It is particularly gratifying to learn from legislators that they have been contacted by their local groups interested in public health legislation. The work of the past two years in arousing our members to become politically conscious in their local districts has been very effective.

At this writing, none of the bills in which we are especially interested has passed the legislature. There are twenty-four committees before which public health measures are considered. These committees are in session from early morning until midnight, and your representatives in Sacramento are attempting to cover these committee meetings as well as keep a log of procedure on the floor of the legislature.

There are thirteen bills referring to the subject of health insurance; seven bills amending the Workmen's Compensation Act; a series of four chiropractic bills; the Qualifying Certificate Act; and numerous bills on varying subjects of interest to the members of our Association.

The question most vitally concerning the public and the professions is that of "county medicine" or the opening up of county hospitals. We have repeatedly advised all interested parties that this will be one of the most controversial issues before the legislature. These warnings were carried out on March 27, when Assembly Bill 2397 was introduced by Mr. Heisinger of Fresno County, which would give boards of supervisors powers to provide systems of hospital insurance available to the residents of their respective counties. While the proposal is based on the theory that residents of the counties will subscribe to a hospital fund the bill would give the supervisors power to levy a county tax to defray any deficit. On the opposing side we have the bill prepared by your Council which would regulate county hospitals. This is Assembly Bill 954, introduced by Mr. Kallam of Santa Cruz County. It is being vigorously opposed by the County Supervisors' Association and the State Farm Bureau. The Farm Bureau has been attacking this bill by radio, and will present strong opposition. Taxpayers, civic groups and all individual citizens should immediately interest themselves on this subject.

Lieutenant-Governor Hatfield in the Senate and Speaker Edward Craig in the Assembly made excellent appointments to committees which will deal with public health questions. Safeguarding the interests of the public on these questions are: Honorable Leonard J. Difani, chairman of the Senate Committee on Public Health and Quarantine; Honorable Herbert Slater, chairman of the Senate Committee on Hospitals and Asylums; Honorable Melvyn I. Cronin, chairman of the Assembly Committee on Medical and Dental Laws; Honorable Clifford R. Kallam, chairman of the Assembly Committee on Public Health and Quarantine; and Honorable Gordon W. Corwin, chairman of the Assembly Committee on Hospitals and Asylums.

At the Yosemite session a further report will be made explaining the status of the more important measures.

Respectfully submitted,

Junius B. Harris, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

Charles A. Dukes, Chairman, Cancer Commission.
Fred B. Clarke, Chairman, Committee on Health and Public Instruction.
Morton R. Gibbons, Chairman, Committee on Industrial Practice.
Junius B. Harris, Chairman, Committee on Public Policy and Legislation.
Daniel Crosby, Chairman, Committee on Hospitals, Dispensaries and Clinics.
Harry H. Wilson, Chairman, Committee on Membership and Organization.
John H. Graves, Chairman, Committee on Medical Economics.
Clarence G. Toland, ex officio, President of California Medical Association.
Robert A. Peers, ex officio, President-elect.
Frederick C. Warnshuis, Secretary.
Hartley F. Peart, Attorney, Legal Counsel, California Medical Association.

To the President and the House of Delegates:

Your Committee on Public Relations respectfully submits the following report:

Your committee prepared and supervised exhibits at the San Diego Fair, the Sacramento State Fair, and the Los Angeles County Fair at Pomona.

On October 1, the committee's present director assumed the duties of office. Since then your committee has pursued the following activities:

1. Enrolled the coöperation of Woman's Auxiliaries to impart information on medical questions for the purpose of engendering sound public opinion in health matters.

2. Obtained photographs of the scientific exhibits of the Century of Progress for the purpose of building a series of exhibits and having them available for fairs and other educational exhibits.

3. Contacted officials of the San Diego Fair and assumed sponsorship of the medical exhibits at that fair. This insured a high type of exhibits, and prevented the admission of undesirable exhibits from questionable sources.

4. With the assistance of the American Medical Association Bureau of Public Health, your committee has made available to Woman's Auxiliaries and lay groups, radio talks, health literature, and medical information.

5. Your committee has established a reference library at headquarters. This library contains some fifteen hundred pieces of literature and reference works. It is being enlarged monthly by new additions. This reference library is at the service of members and the public, and seeks to furnish information upon all health, medical and economic subjects, the object being to provide a central bureau of dependable information. A sustained effort is also being made to induce the public to consult this reference library when seeking knowledge on these topics. During the past month eighty-six public inquiries were received.

6. Public libraries have been supplied with lists of dependable books dealing with medical and economic subjects.

7. Editors of daily papers have been contacted and advised that the Director of Public Relations is ready at all times to give information regarding medical and health questions arising in connection with news items or bulletins.

8. Representation was secured upon the State Narcotic Commission. This Commission has agreed to submit all its narcotic literature for editing and approval by our director.

9. A Bureau of Public Health Education has been established, and a corps of speakers has been enrolled and a schedule of public meetings has been arranged. Speakers are being sent to luncheon clubs and meetings of the Grangers, Parent-Teachers and other lay groups. The truth of scientific medicine is being brought to the public by teachers, not advocates. Your committee feels this to be a most important function, and proposes to press this movement so as to reach every community in the State. As soon as possible a schedule of lectures for high school assemblies will be inaugurated.

Conclusion: Your committee is of the opinion that it has formulated, after careful thought and deliberation, the fundamentals of a sound program of work. These will be developed and expanded by a sustained supervision. It may be confidently expected that from these activities great good and benefit will accrue to the public and to the profession. Your committee respectfully requests endorsement and approval, and urges that county societies subscribe their unrestricted coöperation.

Respectfully submitted,

Charles A. Dukes, *Chairman.*

COMMITTEE ON PUBLICATIONS

Percy T. Magan, Chairman, 1937

Ruggles A. Cushman, 1935 — Frederick F. Gundrum, 1936
The Editor, ex officio — The Secretary, ex officio

To the President and the House of Delegates:

It gives us sincere pleasure to state that an inspection of the official journals of state medical societies, as one views them on the shelves of medical libraries, reveals the fact that California and Western Medicine, both in its material make-up and its contents, ranks most favorably with any and all of these others. Naturally enough this causes a feeling of "mental well-being," as it is a tribute to those charged with the editing work and the members of the Association who contribute the scientific articles.

Last year, in the report of this committee, attention was called to the advantages of having no advertising on the outside front cover, the reasons for this being that it made for greater ease in studying the contents and also added to the attractiveness and dignity of the appearance of our official journal. In our judgment, this procedure should be continued. The general order of the table of contents is that which is in vogue in the majority of medical journals, and the maintenance of such a set form, if it is satisfactory and handier for the majority of the readers of the publication, seems desirable. From time to time during the year now past and gone, the editor of our Journal has consulted with the chairman of the Publications Committee when matters of special policy needed definite decisions.

It is to be regretted that because of the greatly reduced income from advertisements it has not been possible, on the allocation of subscription funds inaugurated in prosperity years of days gone by, to keep the bookkeeping entries from showing a deficit on the Journal operations. However, it is comforting to know that practically all publications in this period of economic stress have likewise suffered, and apparently California and Western Medicine less than most of the others. It should be borne in mind, however, that income from advertising could be increased if standards laid down for our advertising copy were lowered. Such a debasement, however, is unthinkable and would not be acceptable to the rank and file of the California Medical Association, since in professing its loyalty to the best in scientific and organized medicine, it naturally wishes to live up to its obligations, even though at considerable loss during these years of economic stress and strain.

On behalf of the Committee on Publications we join with the officers and the editor, and thank members who have contributed articles for their past cooperation, and trust that, in the future as in the past, all will continue to work together in hearty efforts to keep California and Western Medicine in the very van of state medical society publications.

Respectfully submitted,

Percy T. Magan, *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

Frederick C. Warnshuis, Chairman

J. Homer Woolsey, 1935 — Lemuel P. Adams, 1937

F. M. Pottenger, 1936 — Fletcher B. Taylor, ex officio

William P. Kroger, ex officio

To the President and the House of Delegates:

The scientific program for this annual session summarizes your Scientific Committee's achievements. During three committee meetings every detail of the program received careful consideration. Your committee is of the opinion that the subjects reflect medical progress and are of educational value.

Your Committee has one outstanding recommendation: We urge that members interested in a special field of medicine embrace the opportunity of attending other section meetings when their particular section is not in session. Doing so will enable these specialists to remain conversant with the progress recorded in the other branches of medicine.

Your committee records its appreciation to our guests and members who are participating in this program.

Respectfully submitted,

Frederick C. Warnshuis, *Chairman.*

REPORTS OF COMMISSIONS, SPECIAL AND COUNCIL COMMITTEES

AUDITING COMMITTEE

Executive Group

Karl L. Schaupp, Chairman

Morton R. Gibbons — O. D. Hamlin

To the President and the House of Delegates:

Since the last annual meeting of the House of Delegates there has been a thorough recheck by new auditors of the financial system of the California Medical Association. A number of important changes have been made, increasing the efficiency of the accounting system and making certain financial savings. The Auditing Committee has scrutinized all of the expenditures during the year and has approved, as set forth in the Constitution and By-Laws, all expenditures that were properly authorized.

The books of the Association have been audited and found correct by Ernst and Ernst, certified public accountants.

Respectfully submitted,

Karl L. Schaupp, *Chairman.*

CANCER COMMISSION

Executive Group

Charles A. Dukes, Chairman

Lyell C. Kinney, Vice-Chairman

Alson R. Kilgore, Secretary

Orville Meland, Secretary for Southern Section

Harold Brunn — Gertrude Moore

Henry J. Ullmann — A. Herman Zeiler

Clarence G. Toland

To the President and the House of Delegates:

California and Western Medicine carried in its January issue the final report of the series of committee studies undertaken three years ago by the Cancer Commission. All the reports have been reprinted in collected form and a copy mailed to each member of the Association.

With this part of its program completed, the Commission has turned to other lines, particularly to a program of sustained public education. A speakers' bureau, carefully selected to present the Association's accepted views on cancer, is being organized in coöperation with the similar bureau of the Department of Public Relations on general subjects. Speakers will be available to lay groups of all kinds, and an effort will be made to secure as wide opportunity as possible for the presentation of cancer facts, always with the cooperation and sponsorship of county medical societies.

The Commission feels very strongly that members of the profession should continue to improve their diagnosis and treatment, especially of early cancer, and recommends that all county societies be urged to devote at least one meeting each year to this subject. The Commission will gladly coöperate in arranging programs.

Contact has been made by the Commission with exhibitors of cancer displays at the Chicago Exposition, and it is expected that a valuable cancer exhibit will be included in the San Diego Exposition this summer.

Respectfully submitted

C. A. Dukes, *Chairman.*

SPECIAL COMMITTEE ON A QUALIFYING CERTIFICATE (BASIC SCIENCE) ACT

George H. Kress, General Chairman

Morton R. Gibbons, Chairman (for Bay Region)

Percy T. Magan, Chairman (for Southern California)

Junius B. Harris, Chairman (for Remainder of State)

To the President and the House of Delegates:

A qualifying certificate law, drafted along lines indicated in former issues of California and Western Medicine (March, 1934, pages 194 and 211, and November, 1934, page 339) has been introduced into the California Legislature, which is now in session, as Assembly Bill 1552. This Act, as drafted, is a composite of several basic science laws of eastern states, designedly modified with special reference to California.

Since the introduction of the tentative draft, many suggestions have come to the committee, and these will be carefully considered. Copies of the bill, as thus far drafted, may be obtained by sending a request to the State Printer at Sacramento.

The decision as to whether passage of a qualifying certificate law should be pressed during this session of the present legislature rests with the California Medical Association Council. An earnest effort will be made to include all desirable modifications, and to give support to only that kind of law which will work to the best interests of the public health and the healing art professions.

Respectfully submitted,

George H. Kress, *Chairman.*

COMMITTEE ON ARRANGEMENTS—ANNUAL SESSION

Hartley G. Dewey, Yosemite, Chairman

Clarence G. Toland, Los Angeles

Lemuel P. Adams, Oakland — Robert A. Peers, Colfax

Eleanor Seymour, Los Angeles

To the President and the House of Delegates:

Practically all of the arrangements for the coming session have been perfected through the secretary's office. Your committee therefore has no report of action taken, but merely holds itself in readiness to be of assistance at the time of the annual meeting. The chairman has checked the plans with the management of the Yosemite Park and Curry Company and can assure the delegates that the arrangements for hotel accommodations, meeting rooms, and recreation should insure a pleasant and successful session.

Respectfully submitted,

Hartley G. Dewey, *Chairman.*

"A host of incidents in the Great War showing incredible vitality and endurance and the tenacious power to live by men terribly and fantastically wounded, the way in which a mother can remain alert and efficient during the crisis in the illness of a child, an illness which may last for days—all these are indications of significant possibilities, both biological and psychological, inherent in the human organism. However, the vitality of human beings has its limitations. It diminishes with the years, reaching its lowest ebb in old age, and yet even here the most amazing variations are encountered."

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

CLARENCE G. TOLAND.....President
ROBERT A. PEERS.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

OFFICIAL NOTICE

Reduced Railroad Fares to Yosemite Valley—Send for Certificate.—Arrangements have been made for a fare and one-third for railroad travel to and from Yosemite National Park.

If you plan to travel by train, write to the State Secretary for a certificate that will authorize your local agent to sell you a ticket at reduced rates.

You must have this certificate to obtain reduced rates.

MONTH'S ACTIVITIES

There were of course the several time-consuming details in arranging for the special meeting of the House of Delegates, credentials, mimeographing of reports that were sent to the delegates in advance of the meeting and local arrangements in Los Angeles. Following the meeting the main resolution was sent to every county society. This was followed by the preparing of the minutes that are contained in this issue.

The Council had an all-day session on March 2 and a final session on March 3.

The Committee on Public Relations met on March 2 and reviewed its program of activity which will be imparted at the annual session.

On Monday, March 4, President Toland and your Secretary went to San Diego and conferred with a committee from that society and the manager of exhibits of the San Diego Fair. The result of this conference was that sponsorship and censorship of all medical and therapeutic scientific exhibits in the Hall of Science was assigned to the California Medical Association in coöperation with the San Diego County Medical Society. A high type of exhibits and the elimination of all questionable pseudoscientific exhibits is thereby assured.

On Tuesday evening, March 5, it was your Secretary's privilege to meet with the alert members of the San Bernardino County Medical Society. Every praise is due to this aggressive county unit and its efficient secretary.

On Wednesday, March 6, it was a privilege again to meet and address some two hundred members of the Bay branch of the Los Angeles County Medical Association in Long Beach. The chairman of the Council, Dr. T. Henshaw Kelly, accompanied your Secretary to San Bernardino and Long Beach and discussed organizational problems.

On Thursday evening, March 7, it was inspiring to meet with the members in Stockton.

As your Secretary visits these county units he is deeply impressed with the high type, sincerity and spirit of all who are affiliated with organized medicine. It is a privilege and a joy to meet these men of medicine. Inspiration is gained.

On Friday, March 8, there was a joint meeting of the Association's Committee on Pathologists and Roentgenologists with representatives of California hospitals. The committee will report at the annual session.

On Saturday, March 9, there was a meeting of the newly created special committee that is to coöperate with the Senate's Interim Committee. The committee met with the Senate Committee on March 12 in Sacramento.

Tuesday night, March 12, our economic problems were presented to the San Francisco County Society.

On Friday, March 15, the engagement to speak to the Alameda County Woman's Auxiliary was filled.

On Sunday, March 16, the meeting of the Placer County Society was attended, in company with President Toland and President-Elect Peers, and on Monday the same State officers were accompanied to the meeting at Red Bluff.

On March 20 it was your Secretary's privilege to attend and address the meeting of the Santa Clara County Society.

Your Secretary appreciates the friendly receptions accorded to him at these several places and is grateful for the kindness shown him.

STATE AND COUNTY SOCIETY ACTIVITIES

CALIFORNIA ADOPTS A POLICY

In committing itself in the resolution adopted at the special meeting, the California Medical Association has formulated a principle and a policy. The position taken is sound professionally and economically. It is consistent with the pronouncement of the American Medical Association which left open a way for county and state societies to adopt such plans as are honest, controlled, and which incorporate in their provisions certain definite fundamentals.

Criticism of California's action will probably be forthcoming from other states and individuals. Before voicing opinions it would be well for critics to become informed as to California conditions and state problems that confront its people, the legislature, and the profession. These facts will temper all who are inclined to assume a "thumbs down" position. The diversity of geographical features, the distribution of population, the character of industry, and many other factors create conditions that are not comparable to conditions in other states.

This Association has always been the first to recognize the needs of the profession and the people of the State. It has always acquitted itself of all its responsibilities. In this particular instance, the delegates representing the profession, after mature study, deliberation, and discussion, recorded their judgment. A policy was adopted for sound judgment indicated that such was the proper course. This Association will stand upon the platform provisions of the resolution and by judicious actions strive to attain a satisfactory way in which to accord adequate medical care to all residents of the State. In doing so, it is quite possible for California, by reason of its experiences, to point out to other states the way in which to solve their similar problems.

The adopted resolution is appended:

RESOLUTION NO. 2 INTRODUCED BY DR. IRVING S. INGBER AS AMENDED BY THE COMMITTEE

WHEREAS, The studies of the Committee of Five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

WHEREAS, Because of this economic situation proper medical care is beyond the reach of this population group; and

WHEREAS, It has been established that this problem can be alleviated by the utilization of the insurance principle; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital;
2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system;
3. There shall be no provision for cash benefits
4. The patient shall receive adequate treatment and his physician shall receive adequate compensation;
5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession; and be it further

Resolved, That the California Medical Association immediately offer its full aid and coöperation to the Interim Committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

Resolved, That there be formed a special committee authorized and empowered to act herein, constituted as follows: the Legislative Committee of the Association and three members of the Association to be appointed by the Speaker of the House.

The Special Committee consists of T. Henshaw Kelly, chairman; Joseph Catton, secretary; Walter B. Coffey, Junius B. Harris, E. T. Remmen, and Fred A. DeLappe.

The following constitute the Advisory Committee to the committee:

Clarence G. Toland, Los Angeles.
Rodney A. Yoell, San Francisco.
LeRoy Brooks, San Francisco.
Victor W. Hart, Yreka.
Lemuel P. Adams, Oakland.
L. A. Packard, Bakersfield.
William W. Roblee, Riverside.
A. J. Scott, Los Angeles.
Robert A. Peers, Colfax.
Irving S. Ingber, San Francisco.
Dewey Powell, Stockton.
Edward M. Pallette, Los Angeles.
Henry Dietrich, Los Angeles.
Loren R. Chandler, San Francisco.
Langley Porter, San Francisco.
Lyell C. Kinney, San Diego.

* * *

PUBLICITY AGENT

The Council has authorized its chairman to employ a publicity agent. The services of Mr. Milton Silverman have been secured, and the following public announcement has been made:

Memo to the City Editor:

Beginning this week, the California Medical Association presents its news service for California papers. Two sets of news releases will be provided, one for daily papers and one for weeklies. There will be no duplication.

In addition to a regular weekly release, you will receive additional stories whenever they break. Unless otherwise advised, we will send all this material to you directly by mail. Certain spot news stories, of course, will be sent through Associated Press, United Press, and International News Service.

This office will gladly send special material upon request, and is prepared to offer its services at any hour, day or night, when you require immediate and reliable information on medical subjects.

The California Medical Association has nothing to sell. This service is being sent to you solely so that you may have a constant supply of *accurate*, timely news stories which will bring to your readers a picture of the daily progress of medicine.

These stories are checked before mailing; therefore, we request that you cut whenever necessary, but do not rewrite.

Very truly yours,
MILTON SILVERMAN,
Public Relations Counsel.

(Wire: California Medical Association, 450 Sutter Street, San Francisco.)
(Phones: Day, DOuglas 0062; night, FIllmore 2113 or WAlnut 8671.)

It is hoped that the imparting of dependable information to the public will build up sound opinion in regard to medicine and public health and make for a better understanding.

* * *

OUR SIXTY-FOURTH ANNUAL SESSION

This issue contains the program for our sixty-fourth annual session in Yosemite National Park, May 13 to 16.

On Sunday, May 12, the Association's Cancer Commission will conduct a clinical-pathological conference. Members are requested to bring their microscopes.

The Council will meet Sunday, May 12, at 8 p. m.

As one familiarizes himself with all the features of this exceptional program, the conclusion will be reached that he can ill afford not to attend. Four days of enjoyment and profit await all who register at this annual session.

Hotels.—The following rates have been made:

AMERICAN PLAN

The Ahwahnee—Capacity, 225. Each room with private bath.

Two in room, $8 per person per day.
One in room, $10 per day.

Camp Curry—Capacity, 1,200.

Rooms with bath:
Two in room, $5.50 per person per day.
One in room, $7 per day.
Rooms without bath:
Two in room, $4 per person per day.
One in room, $5 per day.
Tents without bath:
Two in tent, $3.50 per person per day.
One in tent, $4.50 per day.

EUROPEAN PLAN

Yosemite Lodge—Capacity, 300.

Rooms with bath:
Two in room, $3 per person per day.
One in room, $4 per day.
Rooms without bath:
Two in room, $2 per person per day.
One in room, $3 per day.
Members should write for their reservations.

Railroads.—Special sleepers will leave Los Angeles and San Francisco on Sunday night, May 12, for Merced and El Portal. See local ticket agent for reservations. Return sleepers, Thursday night.

The Yosemite will be at its best during the days of the meeting. Plan now to go and profit by the exceptional scientific program that has been arranged. Enjoy the scenery of Yosemite Park. You will be well repaid.

Accommodations Still Available.—In spite of the fact that rooms and baths at the Ahwahnee and Camp Curry have been reserved, there are desirable rooms, cabins, and cabin tents still available. Better write today.

* * *

RAILROAD ACCOMMODATIONS TO YOSEMITE NATIONAL PARK

The appended letter is self-explanatory. If you intend going by rail, write to the State Secretary for certificate that will entitle you to a reduced rate.

"Confirming conversation of today:

"The Southern Pacific Company will arrange to operate sleeping cars from both San Francisco and Los Angeles to El Portal in connection with the Yosemite Valley Railroad and Yosemite Valley transportation system for the California Medical Association members. Following is the schedule from San Francisco and Los Angeles:

"Leave San Francisco Ferry.....11:40 p. m.
"Arrive Yosemite Valley.....10:05 a. m.
"Leave Los Angeles..... 6:00 p. m.
"Arrive Yosemite Valley.....10:05 a. m.

"Both parties joining at Merced, 5:30 a. m. We suggest that sleepers leave Los Angeles and San Francisco the night of May 12, arriving at Yosemite Valley on the morning of May 13.

"Following are the Pullman rates:

"From San Francisco:

Lower	$2.50	Compartment	$7.00
Upper	$2.00	Drawing room	$9.00

"From Los Angeles:

Lower	$3.00	Compartment	$8.50
Upper	$2.40	Drawing room	$11.00

"Rail rate from San Francisco is $10.85; from Los Angeles, $15.80.

"Members may secure Pullman reservations by applying to their local Southern Pacific agent, or directly through Mr. E. J. Harris, 95 Market Street, San Francisco, phone Douglas 1212.

"We are not submitting return schedules as we believe the majority of the members will desire to return to San Francisco and Los Angeles on day schedule. However, if they wish to use sleepers, same can be arranged.

"Trusting the above information will assist you in your plans, we are

"Cordially yours,

"EARLE J. HARRIS."

Southern Pacific Company,
95 Market Street, San Francisco.

* * *

THE OPTICAL CODE AND OPHTHALMOLOGIST RELATIONSHIP

Many of our members who are engaged in the specialty of ophthalmology have received from the Optical Retail Trade Code Authority a questionnaire and a request to remit $3 when they subscribe to this code.

The Bureau of Legal Medicine and Legislation of the American Medical Association has protested this ruling and the attitude on the part of the Trade Code Authority. This same Bureau recommends that, pending the adjustment of the protest, physicians that are engaged in strictly professional work are advised to refrain from answering the questionnaire and also refrain from paying the attempted assessment.

The outcome of the protest will be promptly reported in *The Journal of the American Medical Association.*

* * *

SALUTATION OF DAWN

Listen to the exhortation of Dawn!
Look to this day!
For it is Life, the very Life of Life.
In its brief course lies all the
Varieties and Realities of your Existence:
The Bliss of Growth,
The Glory of Action,
The Splendor of Beauty;
For Yesterday is but a Dream, and Tomorrow is but a Vision,
But Today well lived makes
Every Yesterday a Dream of Happiness,
And every Tomorrow a Vision of Hope.
Look well, therefore, to this Day!
Such is the Salutation of the Dawn.

(Osler in his address, "The Way of Life.")

* * *

WORTH PONDERING OVER

We do not know where we are drifting; none of us know, but I have the courage to play the game and the faith to believe that the physician of character and skill, the world will always find a suitable reward and a place of dignity, not as a mere cog in a piece of machinery, but as a councilor who fills a human and thoroughly personal relationship.—McLester.

* * *

Relative values of sense and sentiment are not determinable. So-called thinking is too often an expression of emotional response and bears small resemblance to weighing, measuring, and comparing.

* * *

Notwithstanding so-called "forgiveness," the buried impression of a rank injustice will be revivified from time to time.

Therefore, to "ignore" as far as possible, and through exercise to develop a helpful sense of humor in an irritating situation, constitute the wiser policy.

* * *

It is for the medical profession to determine now whether, under the pressure of the hour, we must cripple or abandon the heritage of our professional independence for some new philosophy which must mark the passing of that freedom. These intellectual and scientific freedoms cannot thrive except there are also economic freedoms.

* * *

Membership in your county and state medical organizations retains for you a militant force ever alert to conserve your professional interests. For the dues you pay it would be impossible to retain an agent as capable or active as is your county and state medical organization.

COUNCIL MINUTES

Minutes of the Two Hundred and Thirty-First Meeting of the Council of the California Medical Association

The following minutes were approved by mail vote of the Council.

Held in the Lounge of the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles, March 1, 1935, at 9:30 a. m.

1. **Call to Order.** — The Council of the California Medical Association convened in special session in Los Angeles at 10 a. m., Friday, March 1, 1935, with the chairman, T. Henshaw Kelly, presiding, and the following members present: Doctors Clarence G. Toland, president; Robert A. Peers, president-elect; E. M. Pallette, speaker; T. Henshaw Kelly, chairman of Council; Karl L. Schaupp, chairman of Executive Committee; Councilors W. W. Roblee, Carl R. Howson, Henry J. Ullmann, F. R. DeLappe, A. L. Phillips, O. D. Hamlin, C. E. Schoff, Henry S. Rogers, Harry H. Wilson, J. B. Harris, C. O. Tanner, W. H. Kiger, Morton R. Gibbons, C. A. Dukes, chairman of Committee on Public Relations; George H. Kress, editor; F. C. Warnshuis, secretary; and General Counsel Hartley F. Peart.

2. **Employment of Court Reporter.**—The Council considered the desirability and advisability of employing a court reporter to record the discussions and actions of the special meeting of the House of Delegates.

After full discussion, it was moved by Councilor Ullmann, seconded by Councilor Rogers, that the secretary be authorized to secure the services of a court reporter for the special meeting of the House of Delegates. Carried.

3. **Payment of Delegates' Expenses.**—The secretary presented the question of payment of railroad expense of delegates attending the special meeting of the House of Delegates.

Moved by President Toland, seconded by Councilor DeLappe, that the round-trip fare and cost of lower Pullman berth be allowed delegates, councilors, and Association officers, attending the special session. Carried.

4. **Financial Statements.**—The secretary presented the financial statements for the months of December, 1934, and January, 1935.

Moved by President Toland, seconded by Councilor Schaupp, that the financial statements for the months of December, 1934, and January, 1935, be approved. Carried.

5. **Cancer Commission.**—The secretary stated a question had arisen as to the sponsorship of the pathologic conference held on the Sunday preceding the annual session.

Moved by Councilor Ullmann, seconded by Councilor Phillips, that in view of the fact that the Cancer Commission, under authorization of the Council, has successfully conducted these Sunday conferences preceding the annual session, the Council believes that the conferences should continue to be presented under the auspices of the Cancer Commission. Carried.

6. **Report of Auditing Committee.**—Karl L. Schaupp, chairman of the Auditing Committee, presented the following report:

Your Auditing Committee met on February 11, 1935, to review the recommendations of the Association's auditors and submits the following recommendations to the Council:

1. That the bank salary account be closed. That salaries for the office staff be paid from the Revolving Fund.

2. That a Petty Cash Fund of $50 be continued.

3. That the Revolving Fund be reduced to $750. That it be reconciled in the Cash-Journal Ledger each month. That expenditures through the Revolving Fund be limited to salaries and immediate disbursement requirements. That all disbursements, in so far as possible, be by means of the regular Association voucher.

4. That all purchases be made through a purchase order form signed by the Secretary under authority given by the Council.

5. That a monthly trial balance be filed in the Cash-Journal. Said trial balance to show unexpended appropriation balances.

6. That the value of office furniture be written off and carried in reserve statements at $1. That an inventory be made and filed annually in the Council minutes.

7. That all control accounts be entered in the general ledger.

Respectfully submitted,

KARL L. SCHAUPP, *Chairman*
MORTON R. GIBBONS
O. D. HAMLIN

Moved by Councilor DeLappe, seconded by Councilor Rogers, that the report of the Auditing Committee be accepted, and the Auditing Committee's report on suggested changes in the office financial department be approved. Carried.

7. **Postgraduate Conferences.** — The secretary reported on the present status of postgraduate conference plans and suggested that an appropriation be made to cover expense entailed in presenting programs.

Moved by President-Elect Peers, seconded by DeLappe, that the suggestion of the secretary that $1,500 be allocated for these postgraduate conferences be accepted and that a committee, consisting of the president, the president-elect, the chairman of the Auditing Committee, and two councilors, appointed by the chairman, formulate rules of procedure for the expenditure of the funds. Carried.

8. **Mendocino and Lake County Physicians.**—A letter from the secretary of the Mendocino County Society suggesting that Lake County physicians affiliate themselves with the Mendocino Society was read.

Moved by Speaker Pallette, seconded by President-Elect Peers, that Dr. Henry Rogers, councilor of the district, be requested to investigate the situation and report to the Council at the Yosemite meeting. Carried.

9. **Badges.**—Moved by President-Elect Peers, seconded by Editor Kress, that the usual ribbon badges be furnished members attending the Yosemite session. Carried.

10. **W. B. Coffey Correspondence.**—A letter from Fred R. DeLappe requesting further consideration of the correspondence from Doctor Coffey regarding replies to inquiries requesting information on the Coffey-Humber cancer extract, was read. Doctor DeLappe opened the discussion, questioning the interpretation of the resolution adopted by the Council on January 21, 1933. Full discussion was had.

Moved by Councilor Schaupp, seconded by Councilor Gibbons, that the chairman reply to Doctor Coffey to the effect that the resolution contained in the minutes of the Council of January 21, 1933, was passed, that it was passed at the time without intended or implied malice on the part of the Council or any member of the Council, that the Council feels that possibly it had acted hastily and that it regrets that action. Carried.

It was agreed that the letter should be approved before mailing by Doctors Gibbons and Schaupp.

11. **Membership Roster.**—Moved by Councilor Roblee, seconded by Councilor Gibbons, that the membership roster, consisting of names and keyed addresses, be published in an early issue of the JOURNAL.

12. **Publication of Committee on Public Relations Minutes.**—Moved by Editor Kress, seconded by Councilor Phillips, that hereafter digests of the minutes of the Public Relations Committee be published in the JOURNAL. Carried.

13. **Publication of Journal.**—It was the sense of the Council that the March issue of the JOURNAL should be delayed to permit the incorporation of action taken by the House of Delegates.

14. **Lien Bill.**—It was reported that a lien bill was considered inadvisable at the present time.

15. **Disciplinary Procedures.**—Moved by Councilor Ullmann, seconded by President Toland, that the regulations covering disciplinary procedures be referred to the Executive Committee for review, with power to act. Carried.

16. **Constitution and By-Laws.**—The general counsel reported on the Constitution and By-Laws for the Sacramento Society. A request was also received from the secretary of the Sacramento Society stating that the corporate life of the Sacramento Society for Medical Improvement had expired; the Society had adopted a new Constitution and By-Laws and requested the Council to issue them a new charter under the name of the Sacramento County Medical Society.

There was some discussion on the part of members of the Council regarding the change of the name. It was recalled that the Sacramento Society for Medical Improvement was the mother county organization of the State and that many historical memories are associated with that society and that name. It was suggested that the Sacramento Society be informed of this sentiment and that they reconsider their action in changing the name of their organization and that their request for a new charter be deferred until the annual session in May.

17. **Ben Franklin Insurance Company.** — Moved by Councilor Ullmann, seconded by Councilor Schaupp, that the decision as to whether the counsel should write a brief in the Ben Franklin case be left to the president, the chairman of the Council, and the secretary. Carried.

18. **Pacific Employers Insurance Company vs. Mitchell.**—The general counsel reported on the status of the above case, stating that the case was to be appealed to the Supreme Court.

19. **Francis vs. Nelson.**—General Counsel Peart reported on the status of the case of Francis vs. Nelson.

20. **Survey of Legal Expenses.**—William W. Roblee, chairman of the Special Committee on the Survey of Legal Expenses, read the following report of his committee:

REPORT OF THE SPECIAL COMMITTEE ON SURVEY OF LEGAL EXPENDITURES OF THE CALIFORNIA MEDICAL ASSOCIATION

The committee has investigated the expenses and activities of the legal department for the years 1931-1934 inclusive, and reports as follows:

Historical.—The legal department was instituted in 1907. Mr. Hartley Peart of San Francisco became an associate attorney for the Association in 1915, became attorney in 1917 and has continued in that capacity since that time. Mr. Hubert Morrow of Los Angeles was an associate attorney until 1930, when he ceased to be retained in that capacity, but he has been employed from time to time for special work in southern California.

Salary.—Mr. Peart receives an annual retainer of $4,000. Extra retainer services of Mr. Peart, other attorneys and legal expenses are authorized from time to time by the Council.

Services Rendered.—These can be placed under two classifications: (*a*) Those cared for by the retainer, (*b*) those that may be termed extra retainer.

Retainer Services.—No one who is not in active relationship to the work of the Association can appreciate the volume of details that are referred to Mr. Peart for advice and decision. Much of this work does not lend itself to tabulation in a report. There are numerous contacts with both individuals and organizations by letter, telephone and personal contact of which no detailed record can be made. Our attorney has been most responsive to such requests and his twenty-two years of experience in evaluating our problems has enabled him to be most helpful.

We are attaching hereto* (1) a list of the major activities covered by his retainer (2) a detailed list of services rendered in two typical months as shown by his records and taken at random, and (3) a list of the major activities actually covered by his department during the past five years.

In this connection we wish to report that the committee, through Secretary Warnshuis, has contacted the State Associations of a number of other states where societies compare fairly closely in numbers and activities to the California Medical Association and in none of them do we find that the legal problems are cared for with such diligence and detail as is the case with our Association. It appears that California is the most fertile field in the Union for fads and fancies, medical and sociological, all of which require attention, evaluation and watchfulness on the part of your representatives lest something be

* Copies of lists and tabulations on file in secretary's office. Copies of same will be mailed councilors as soon as prepared.

Detailed record of all cases and all services rendered are regularly kept at the office of the general counsel, including services and cases of the California Medical Association.

foisted upon us that will be dangerous and in many instances most harmful. Copies of the letters referred to are attached hereto.

Extra Retainer Expenses.—We are attaching hereto a tabulation of legal department expense for the years 1930-1934 inclusive. . . .

The extra retainer expense can be subdivided as follows: (1) litigation, (2) medical service plans, (3) miscellaneous.

Litigation.—The following cases were held over from the former malpractice defense activities of the Association and no more of this character will occur. It appears that judgments were cared for by the malpractice defense fund but that the expenses of the court proceedings were a charge against the Association:

Johnson vs. Nolan	May, 1930
Roman vs. Nolan	Jan., 1930
Dunn vs. Duffrey	Feb., 1930
Hanson vs. C. E. Reed	Aug., 1930
Gilbertson vs. Gibbons	May, 1930
Phelps vs. Stoddard	June, 1932

The following cases against individual doctors were given assistance because in each instance a principle was to be established which, if it became basic law, would affect the profession as a whole.

Blair vs. McCord—A case where a doctor was accused of assault in that it was alleged that he operated without the patient's consent.

Webb vs. LeWald Coal Company—To establish the confidential relation of a physician to a patient examined by him, even though he was not in direct attendance.

Reynolds vs. Struble—A case involving two principles:

1. Whether the opinion of a physician called as an expert should be discredited if he was not paid a fee for his testimony.

2. A vital decision for the roentgenologist having to do with the nature and interpretation of x-ray films.

Francis vs. Nelson.—A case now pending before the State Supreme Court adjudicating the right of a nurse or other person, not a doctor of medicine, to give anesthetics.

County Hospitals.—For several years the question as to the right of the County Hospitals to admit pay patients has become more and more a source of irritation. Various counties had built commodious and expensive hospitals. Not only were indigents and part-pay patients in the very low income brackets admitted, in some counties all the people were welcomed. They were hospitalized, treated and cared for by a volunteer or salaried attending staff for a fee that could not be competed with by private institutions and physicians. The law seemed quite definitely to prohibit such practice and the Council decided it well to assist some citizens and taxpayers in Santa Barbara in bringing a test case to determine the question. The suit was instituted by a citizen and we gave both moral and legal assistance in the case. The proceedings progressed slowly.

In the meantime the situation in Kern County became so acute that members of the Kern County Medical Society entered a similar suit there. The suit in Santa Barbara County was slow in developing for various reasons; the Kern County suit became very active, the men there were carrying a heavy burden. We could not afford to risk an adverse judgment for lack of vigorous and effective prosecution so our activities were of necessity centered there. The legal work done on the Santa Barbara test case was used as a basis in the Kern County case and an affirmative decision won. The case is now before the Supreme Court on appeal. No expense was incurred in Santa Barbara beyond that already authorized after the Kern County suit developed.

We have used the legal material developed in these two suits in advising ten other county units with reference to County Hospital problems. These cases have cost to date about $6,000 of Association money of which our general counsel was paid $1,000 for work extending about three years. The constituent membership in the counties affected demanded this service and the Council deemed the problem of such vital nature that it instructed our legal department to take action as above summarized.

Medical and Hospital Service Plans.—As early as 1929 some of our members began to insist that changes in our economic plans for the care of sick people of the low income brackets must be instituted. This matter was brought before the Council with great insistence by Dr. Walter B. Coffey and others and a sincere effort was made to evolve a state-wide plan controlled by the Association and based on an insurance or monthly payment principle for the coöperative care of such people. Much study, which involved a great deal of research into the laws which would govern such an endeavor, was given to the subject and the employment of special counsel to assist our legal department was authorized. A practical solution of the problem was not arrived at.

In 1932 Dr. John Hunt Shephard of San Jose, Dr. Rexwald Brown of Santa Barbara, Dr. Rollin French of Los Angeles and others renewed the insistence that something should be done and each presented ideas to the Public Relations Committee, of which Dr. John Graves was chairman. This committee was created by the House of Delegates in 1931 fundamentally for the purpose of evaluating and developing a satisfactory plan looking toward the solution of this problem. As a result of much labor, the so-called "Graves Plan" was evolved and offered to the county units for their use. Up to date no county society has been able to finance or put the plan into operation.

In the meantime the Alameda County Society had evolved a plan similar to others in use elsewhere for the care of indigent and part-pay patients. They followed this by developing a Mutual Hospitals Insurance plan which met all the basic requirements of good business and sound ethics. Certain rulings by the insurance commissioner and difficult financing precluded its adoption by them and it was revamped and offered to the California Medical Association at the Riverside annual session. After prolonged debate it was rejected by the House of Delegates and a Committee of Five authorized, which was ordered to make a state-wide medical economics survey and, if feasible, prepare a bill for introduction at the 1935 session of the legislature. This was to provide for the establishment in this state of an insurance plan for the care of the sick of low income bracket economic station. A very comprehensive survey has been made and the committee will present its findings to the Council and House of Delegates shortly.

This subject has been detailed somewhat at length in order that it may be noted that this has been a continuing effort from the time of its first presentation by Doctor Coffey. A tremendous amount of time has been spent in this work by individuals, the Public Relations Committee and the Council. Our attorney has been active and helpful in trying to chart our course along this as yet untried path in our state and nation. We have our legal principles established, our ethical course outlined and are in a position to guide our interested group. Up to this date in addition to the large group noted above, our attorney has been able to counsel with and guide similar inquiring societies and groups in San Diego, Whittier, Santa Clara, Fresno, San Mateo, Sacramento, San Luis Obispo and San Francisco. The legal work in connection with this endeavor has cost the California Medical Association $6,150 during the past five years.

Miscellaneous Expense.—During the five years there have been $1,275 miscellaneous expenses charged to this department, each item of which is small and can be found in detail in financial statement hereto appended. . . .

Comment

A careful perusal of this report and very close contact with this work from month to month and year to year leads your committee to the conclusion that in no other state have the personal and collective interests of the members of a medical association been given as constant expert and devotel legal service as has been given the California Medical Association.

Our attorney has personal contacts that are invaluable to us and his many years of service in our behalf have given him an insight into our problem and viewpoint such as few laymen possess. The medical profession has organized itself into local, state and national units for the purpose of caring for its interests collectively as it could not possibly do if we were acting as individuals. We commend the legal department for its alertness and service rendered. We advise that it be continued along the same lines as heretofore have proven to be of such signal value to us all.

Recommendations

As your committee reviews our past experience and the economic flux in which we are involved we believe that important decisions will continue to confront us. Individuals, groups, both large and small as well as self-seeking interests, will continue to clamor for this, that and other plans and economic panaceas affecting our interests. We would call attention to the fact that legislation has been instituted and suits precipitated without first obtaining information in possession of the Association and available from its executive officers which would have avoided extra legal expense.

We, therefore, recommend (*a*) that a resolution be presented for adoption by the House of Delegates providing that questions of policy, especially those having legal aspects, be carefully worked out and presented to the county medical societies; that then after due consideration the District Councilor be called in for counsel and advice. If the subject is then found to be obscure or debatable the executive secretary shall be called into counsel on the matter, and then if necessary the matter be referred to the Council and legal department for final action. (*b*) That all requests for legal opinion on any questions involving a fundamental principle be made through the secretary-treasurer.

In support of the above resolution we call attention to:

1. That in this way all interested groups will be carefully guided and prevented from taking unwise or precipitate action such as has occurred in some instances in the past, causing needless labor and expense.

2. That the Councilors are in close touch with these problems and many can be settled quickly through their help.

3. That in Secretary Warnshuis we have a man who, because of long years of experience in both local, state and national economics, is especially well qualified to guide us aright.

4. By this method of procedure our extra retainer legal expense can be kept at a minimum.

Respectfully submitted.

WILLIAM H. KIGER
MORTON R. GIBBONS
W. W. ROBLEE

January 17, 1935.

Moved by Councilor Gibbons, seconded by President Toland, that the report on the investigation of legal expenses be approved and the committee's recommendations contained therein be adopted. Carried.

Moved by Councilor DeLappe, seconded by Councilor Phillips, that all councilors be furnished the entire report for their information and guidance. Carried.

21. **Recess.**—At this point a recess of the Council was taken for luncheon.

22. **California and Western Medicine.** — Discussion was had of publication costs of the JOURNAL. The secretary presented correspondence covering the various bids submitted by publishers. Mr. Will H. Barry, Mr. Nusser, and Mr. Mitchell of the Barry Company addressed the Council. Doctor Kress then addressed the Council.

Moved by Speaker Pallette, seconded by President-Elect Peers, that the Association continue its agreement with the James H. Barry Company for the publication of the JOURNAL in accordance with their letter of February 1, 1935, tendering a reduction of 10 per cent on printing cost. Carried.

23. **Report of Committee of Five.**—Doctor Molony submitted the report of the Committee of Five, which was referred to the House of Delegates.

24. **Legislation.**—The report of the chairman of the Legislative Committee was read.

Moved by Councilor Ullmann, seconded by Councilor Rogers, that a committee, consisting of Doctors Harris, Kelly, Remmen and Mr. Peart, be appointed with power to act in legislative matters and that the Executive Committee be empowered to allocate funds. Carried.

Moved by Councilor Ullmann, seconded by Councilor Rogers, that Doctor Harris be authorized to secure quarters and such help as he requires, and that the expense thereof be authorized, subject to the approval of the Auditing Committee. Carried.

25. **X-Ray Fee Schedule.** — Morton R. Gibbons, member of the Special Committee on X-Ray Fee Schedule, submitted a report for his committee.

On motion duly made and seconded, the following resolution was adopted:

WHEREAS, It has come to the attention of the California Medical Association that effort is being made by the State Compensation Insurance Fund and other insurance companies writing Workmen's Compensation insurance, to reduce fees for industrial accident surgery; and

WHEREAS, In the past the fee schedule of the Industrial Accident Commission has not been adhered to in all instances; and

WHEREAS, The Industrial Accident fee schedule provides such moderate charges for professional services, rendered in accident cases, that to reduce the same would result in great injustice not only to the medical profession, but particularly to citizens suffering from industrial injuries, in that such excessively low fees would undoubtedly lead to inadequate service, thus making for longer temporary disability as well as more and greater permanent disabilities among injured workmen with resultant money loss to insurance companies that would be in excess of the sum saved through lower fee table for professional services; and

WHEREAS, Certain physicians and surgeons, some being members of the California Medical Association, have been guilty of cutting fees below the official fee schedule, and/or have made a practice of underbidding for industrial accident work, other members of our profession and/or have been guilty of rebating to the insurance companies; now therefore be it

Resolved, By the Council of the California Medical Association:

1. That the Council make strong protest to the Industrial Accident Commission against reduction of fees.

2. That the members of the medical profession be advised of their responsibility in the matter.

3. That the fee schedule be reviewed and adequate arguments for adherence thereto be emphasized.

4. That the Industrial Accident Commission be requested to adhere to the fee schedule itself in all its departments and to require recognition of the schedule of insurance companies; and be it further

Resolved, That investigation of and methods for correction of these abuses be at once undertaken by the Committee on Industrial Accident Practice, with the least possible delay.

26. **Sacramento Society.**—Moved by Editor Kress, seconded by Councilor Rogers, that a committee, consisting of Doctors Harris, Peers, Schoff, Toland and Warnshuis, be constituted to confer with the delegates present, calling their attention to the fact that the Sacramento Society is the "mother county society" in California, and there is an historical significance connected with the name, and learn whether the Society wishes to reconsider the changing of the name. Carried.

The secretary was instructed to inform the Sacramento Society that the granting of a charter would have to be submitted to the House of Delegates.

27. **Annual Session.**—The secretary reported on the desirability of securing a court reporter for the meetings of the House of Delegates at the Yosemite annual session and stated that the cost would be approximately $250.

Moved by Councilor Ullmann, seconded by Councilor Rogers, that the secretary be authorized to contact reporters and ascertain a definite bid, and that he be authorized to engage a reporter, subject to the approval of the Auditing Committee. Carried.

28. **County Hospital Reports.**—On motion of Editor Kress, seconded by Chairman of Public Relations Dukes, the following resolution was adopted:

WHEREAS, Lay citizens of California are woefully lacking in knowledge concerning the money value of professional services rendered by members of the medical profession who render gratuitous professional services as physicians or surgeons in the public and semi-public hospitals and clinics of California; and

WHEREAS, For the best interests of all concerned it is desirable that the public at large should be made acquainted with the massive donations annually contributed to the public welfare by medical men and women; now therefore be it

Resolved, That the Council of the California Medical Association respectfully suggests to the Committee of Five that copies of last year's annual reports be secured from all the county hospitals of California, and that the money value of the services rendered by non-salaried staff members of such institutions be properly noted, either in the report of the Committee on Public Relations, or in an appendix thereto; and be it further

Resolved, That, if this be done, that the Executive Committee later on be empowered to investigate the desirability of having reprints of this portion of the report made; such reprints to be sent out by the California Medical Association to mercantile and public welfare institutions and organizations, and to the lay press of California.

29. **Death of Granville MacGowan.**—Moved by Editor Kress, seconded by Speaker Pallette, that the following resolution be adopted:

WHEREAS, Death has taken from our midst Davis Granville MacGowan who, in his half century of medical practice in California, served the people of our State in many public health activities, his colleagues expressing their appreciation of his services by electing him to the presidency of the California Medical Association; now, therefore be it

Resolved, By the Council of the California Medical Association, that the memory of the services which he rendered to his lay fellows and to scientific medicine, redound much to the honor of the medical profession; and be it further

Resolved, That these resolutions be inscribed on the minutes of the Council, and that the sympathy of the members of the Association be extended to the bereaved family.

30. **Publicity Agent.**—The chairman of the Council presented the question of the advisability of employing

an Association publicity agent. The Council engaged in a long discussion of this question.

It was moved by Speaker Pallette, seconded by Chairman of Public Relations Dukes, that the matter of employment of a full-time publicity agent be tabled. Carried.

31. **Kellogg Bill.**—Upon motion duly made and seconded, Doctor Kelly, Doctor Kellogg, and Mr. Peart were authorized to revise bills relating to laboratories, and then present them to the chairman of the Legislative Committee. Carried.

32. **Recess.**—At this point a recess of the Council was taken until 10 a.m. Saturday.

Call to Order—Saturday, March 2, 1935

The meeting was called to order by the chairman, T. Henshaw Kelly.

On motion duly made, seconded and carried, the Council went into executive session.

33. **Office Personnel.**—After discussion of office personnel and organization, on motion of Pallette, seconded by Kiger, and carried, it was

Resolved, That a Committee consisting of the president, chairman of the Council, chairman of the Executive Committee, and Dr. Gibbons, be instructed to recommend changes in the office organization and personnel and that the committee have power to act.

34. **Budget.**—Karl L. Schaupp, chairman of the Auditing Committee, presented the budget, which will be submitted to the House of Delegates.

35. **Publicity Man.**—Moved by Councilor Ullmann, seconded by Councilor Rogers, that the matter of employment of a full-time publicity agent be taken from the table. Carried.

Moved by Councilor Ullmann, seconded by Councilor Rogers, that the Council authorize the employment of a full-time publicity agent at a salary not to exceed $150 per month on a month-to-month basis, traveling expense to be authorized at the discretion of the chairman of the Council and the secretary. Carried.

36. **Public Relations Committee Report.**—Charles A. Dukes, chairman of the Committee on Public Relations, read the committee report, which will be presented to the House of Delegates.

37. **Report to the House of Delegates.**—Moved by Speaker Pallette, supported by Councilor Ullmann, that the chairman appoint a committee of three, consisting of Doctors Howson, Dukes and Kelly, to draw up a statement for presentation to the House of Delegates relative to the subject of health insurance and other medical-economic problems confronting the Association. Carried.

38. **Recess.**—At this point the Council recessed, to convene again at the call of the chair.

39. **Call to Order.**—The Council reconvened at 4 p.m., March 3, 1935, and was called to order by the chairman.

40. **Committee of Five.**—Doctor Molony presented a report on legal expense incurred by a member of the Committee of Five.

Moved by President-Elect Peers, seconded by President Toland, that Doctor Yoell be requested to turn over to the secretary of the Association the legal opinions that he had received and all other legal data in his possession relating to a bill for compulsory health insurance. That upon receipt of the same, and also statements from legal counsel consulted, the secretary be authorized to send to the chairman of the Committee of Five a voucher to cover this service, but not to exceed $1,000. The chairman of the Committee of Five will then, through regular channels of the committee, disburse this amount to those attorneys rendering statements. Carried.

It was the expressed sense of the Council that the Association carry the survey to its logical conclusion, making available the data of the committee, and that the final survey be submitted to the Council for approval.

41. **Publication of Journal.**—Moved by Editor Kress, seconded by President-Elect Peers, that the March issue of CALIFORNIA AND WESTERN MEDICINE be delayed sufficiently to permit publication of the proceedings of the special session of the House of Delegates, and that the secretary so notify all county societies, and that the chairman of the Council, the secretary, and the editor be authorized to edit and print minutes of this special session. Any important corrections to be reported at the annual session.

42. **Health Insurance Resolution.**—Moved by President-elect Peers, seconded by Councilor Ullmann, that copies of the health insurance resolutions be sent to each county society secretary.

Doctor Peers stated that he had submitted a letter to the secretary embodying his stand on health insurance, and that he wished to go on record as being opposed to compulsory health insurance, and asked that it be incorporated in the minutes as follows:

To the Chairman and Members of the Council:

As a member of the Committee of Five appointed by the chairman of the Council, I feel it is my duty to submit a report to the Council on the work of the committee.

As Doctor Wilson, the other member of the committee appointed by the Council, will submit a report regarding the work of the survey and allied matters, I shall confine my report to some general remarks on the need for health insurance, as I see it, and some discussion of the bill for compulsory health insurance which is presented by the Committee of Five to the Council.

1. As to the existence of a need for health insurance: There is no doubt that a large percentage of the population is in an income group which are unable, from their own resources, to pay all or any part of the cost of medical and hospital care when they or members of their families need medical or surgical attention. There has always been this group of people to care for but, because of the present economic crisis, this group is larger than normal. The recent medical-economic survey has furnished a fairly accurate picture of the problem as it relates to the residents of California. Personally I believe, in spite of the great economic distress which is known and accepted by all, that, under present conditions, no one needs to be without competent medical and surgical or hospital care. During all the depression it has been given freely by the medical profession to those in need irrespective of the ability to pay. People have not died nor have they suffered markedly, as claimed by many of the proponents of compulsory health insurance. The sick have been cared for better than ever at the expense of the medical profession.

The survey also depicts rather clearly the way in which the depression has affected adversely the economic status of a large number of physicians and dentists of this state.

2. The demand for remedial legislation: There is no doubt that there is an ever-increasing and quite vocal demand for health insurance. The fact that there are already introduced in the present legislature several bills on health insurance, the fact that in several counties there is a demand for charters with health insurance provisions and the further fact that efforts are being made to secure legislation to open the County Hospitals to all citizens irrespective of financial status are all evidences of the demand. Personally I believe that these demands come not from that part of the population where economic difficulties are the greatest nor do they come from the members of the medical or dental profession as a whole. In my opinion they come principally from self-appointed guardians of the people and are promoted not entirely altruistically but, in some cases at least, for selfish reasons. It is quite evident to all that the actual establishment of any state-wide health insurance scheme would provide many positions—some of them quite well paid. Be that as it may, irrespective of the source of the demand or of the reasons which actuate the proponents of compulsory health insurance, the demand exists, and, if one can judge correctly, is becoming more vocal as time goes on.

3. Is compulsory health insurance the answer? I personally believe that it is not. I make this statement as a result of many months of careful study. My personal feeling is that it will not be to the best interest of either the profession or of the public.

However, the House of Delegates at the 1934 session instructed the Committee of Five "to formulate a plan for the administration of health insurance and to prepare a bill for suitable legislation which may be available for presentation in the 1935 session of the California State Legislature." It is my opinion, sad as it may be, that the resolution carrying this mandate means a bill for compulsory health insurance. Such a bill prepared by a Committee of One of the Committee of Five will be submitted by the secretary of the Committee of Five, Doctor Wilson. It seems to me that the bill is better than many other bills even though it has, to my way of thinking, many features to which I cannot subscribe. It should be gone over carefully by the Council and submitted to the House of Delegates with such suggestions for modification as the Council, in its wisdom, may see fit.

Respectfully submitted,

(Signed) ROBERT A. PEERS.

43. **Resignation of Doctor DeLappe.** — Fred R. DeLappe, Councilor of the Fourth District, submitted his resignation as follows:

To the Council of the California Medical Association:

Having devoted time and service as councilor of the Fourth District for a period of approximately fifteen years, I feel that I have given as much of my time to that service as I can well afford.

Therefore, I am tendering my resignation to become effective as of March 4, 1935.

This action is taken not without regret, for it has been my honor and privilege to serve on that body with groups of as distinguished men as can be found in any organization.

Sincerely trusting that every success may follow all your future endeavors and with this thought in mind, this resignation is respectfully submitted.

(Signed) Fred R. DeLappe.

Moved by Editor Kress, seconded by President Toland, that the resignation of Doctor DeLappe be accepted. Carried.

Moved by Editor Kress, seconded by President Toland, that the following resolution be adopted:

Whereas, Dr. Fred R. DeLappe of Modesto has informed the Council that he has found it necessary to submit his resignation as a member of this body; now, therefore be it

Resolved, By the Council, in reluctantly accepting Doctor DeLappe's resignation, that it express to him the appreciation of its members for his many years of loyal and coöperative effort in the work of the Association; that the secretary send to Doctor DeLappe a copy of this resolution; and that the same be inscribed on the minutes of the Council.

The foregoing resolution was unanimously adopted.

44. **Adjournment.**—On motion duly made, seconded and carried, the meeting adjourned.

T. Henshaw Kelly, *Chairman.*
F. C. Warnshuis, *Secretary.*

COMPONENT COUNTY MEDICAL SOCIETIES

CONTRA COSTA COUNTY

The regular monthly meeting of the Contra Costa County Medical Society was held Tuesday, March 12, at the Hotel Carquinez, Richmond.

President Lucas called upon Dr. J. B. Spalding, who served as chairman of the evening, to introduce the guest speaker, Dr. William Kerr of San Francisco, professor of medicine of the University of California. Doctor Kerr presented a paper on the anatomy and physiology of the heart, and dealt most exhaustively with *Cardiac Irregularities and Their Treatment.* It was one of the most instructive and thoroughly interesting scientific treats the Society has ever had. Much discussion by the members followed.

An application for membership was presented from Dr. Tim Leon of Concord. Accepted.

At the request of Dr. William Powell, county health officer, Doctor Lucas appointed a committee to decide on assistants in the Tuberculosis Clinic.

The next meeting will be held on April 9 at Richmond. The program will consist of:

The Brain from Ape to Man—Warren B. Allen.
Surgery—W. E. Mitchell.
Medicine—A. A. Alexander.

Mrs. W. E. Cunningham very graciously invited all to her home, so the meeting was adjourned at 11:15 p. m. and all repaired to the delightful home of Dr. and Mrs. Cunningham, where we were most delightfully entertained with music and readings, and regaled with delicious refreshments.

Clara H. Spalding, *Secretary.*

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of February 21 at the General Hospital, Dr. Charles C. Falk, Jr., presiding. Eighteen members were present; Dr. C. U. Moore of Portland and H. S. Rogers, State Councilor, of Petaluma, and twelve dentists and sixteen nurses, as guests.

Dr. W. J. Quinn led the discussion on *The Examination of Preschool Children.*

Dr. C. Ulysses Moore read a very interesting paper on *A Study of Osseous Signs of Malnutrition, Especially in Rickets.* Doctor Rogers spoke on *State Medicine and Sickness Insurance.*

Both papers were very well received by our members, Doctors Rogers and Moore being given a vote of thanks for coming to us on this evening.

Lawrence A. Wing, *Secretary.*

KERN COUNTY

The regular meeting of the Kern County Medical Society was held February 21 at the Padre Hotel. During the business session the question of health insurance was discussed at some length. A resolution was introduced and approved by the Society, favoring compulsory health insurance, with the provision that the patient be allowed free choice of physician and hospital.

Doctor Myers gave an interesting talk on *Functional Nervous Diseases in General Practice.* He also gave the Society a brief review of the impending medical legislation.

L. H. Fox, *Secretary.*

ORANGE COUNTY

The regular meeting of the Orange County Medical Association was held on March 5 at 8 p. m. in the chapel of the Orange County Hospital.

The guest speaker of the evening was Dr. Lyle McNeile of Los Angeles. His subject was *Anesthesia in Obstetrics.* He covered the old as well as the newer methods, and named a number of drugs that he has used. His paper was followed by considerable discussion. Drs. George Paulson of Santa Ana and Erving L. Rogers of Cypress were unanimously elected to membership.

The report of the delegates to the meeting in Los Angeles on March 2 was heard.

The secretary was instructed to send a letter of thanks to the Sparkletts Drinking Water Corporation. This company took the members of the medical association and their wives to the Santa Anita Handicap race.

W. S. Wehrly, *Secretary.*

SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held on March 5 at the San Bernardino County Hospital. About eighty-five members and guests were present.

The president made a few explanatory remarks regarding the plan for postgraduate conferences. The following applications for membership were approved: Drs. John H. Hooval, Ontario; Quintus Nicola, Loma Linda; and Clarence E. Dixon, Patton.

Dr. W. W. Roblee, district councilor, made a short talk inviting the doctors' wives to a meeting to be held in Riverside.

Dr. T. Henshaw Kelly, chairman of the Council of the California Medical Association, made a brief address, relating the happenings at the special meeting of the House of Delegates in Los Angeles, March 2 and 3. He also speculated on what might happen with some of the bills pending in the State Legislature. He made a plea for a united stand and the utmost coöperation among physicians.

The program follows:

Asphyxia Neonatorum by Phillip E. Rothman of Los Angeles; *Tetany of the Newborn* by Charles A. Wylie; *The Scope and Functions of the American Medical Association* (motion pictures, with explanatory remarks) by F. C. Warnshuis, Secretary of the California Medical Association.

A. E. Varden, *Secretary.*

SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubroom at 8:15 p. m. on March 7, President C. A. Broaddus presiding.

This was preceded by a supper meeting at the Hotel Clark at 6:15 p. m., at which thirty-eight were in attendance. There were three guests, including Dr. F. C. Warnshuis. Doctor Warnshuis gave a very informative talk on the meetings of the Social Security committees at Washington and the part played by the American Medical Association to steer the plans formulated there in a way that would be acceptable for the profession at large. He also touched on the meeting of the House of Delegates at Chicago in February. He then mentioned several things of interest, among them the meeting at Los Angeles of the California Medical Association delegates, and also his idea of the purpose of the California Medical Association.

A communication from the Stanislaus Medical Society was read, requesting action on a proposed industrial accident x-ray fee schedule. This was referred to Doctors Sheldon, McGurk, and Barbour for study and report. The president then appointed Doctors Hull, Van Meter, and Blackmun to study the advisability of having the California University Extension courses held locally.

Dr. D. R. Powell reported on the recent meeting of the House of Delegates at Los Angeles, and told about the various plans which were discussed for health insurance, and then read the final instructions and resolutions passed for the appointment of a Committee of Three to work with the Senate Interim Committee of Sacramento.

Dr. D. R. Powell then read the following resolution:

WHEREAS, Dr. Fred DeLappe has faithfully and efficiently served this San Joaquin County Medical Society as the district councilor of the California Medical Association for the past fifteen years; and

WHEREAS, Doctor DeLappe has very definitely announced his desire not to stand for reëlection at the next meeting of the Association in Yosemite Valley in May, 1935; therefore be it

Resolved, That the San Joaquin County Medical Society officially express to Dr. Fred DeLappe its sincere appreciation of his long years of splendid service and extend to him its best wishes for a delightful time on his contemplated trip to Mexico City, and a long and successful career; and be it further

Resolved, That a copy of these resolutions be spread upon the minutes of this society, and a copy be sent to Doctor DeLappe.

It was moved the resolution be adopted. Carried.

Dr. Frank Doughty then read the following resolution:

WHEREAS, Dr. Fred DeLappe of Modesto has for the past fifteen years represented the fourth district comprising the counties of Calaveras, Fresno, Inyo, Klngs, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tulare, and Tuolumne on the Council of the California State Medical Association; and

WHEREAS, Doctor DeLappe has definitely determined not to stand for reëlection at the Yosemite meeting of the California Medical Association next May; and

WHEREAS, The San Joaquin County Medical Society has never had the honor of representation on the Council of the California Medical Association; and

WHEREAS, Several delegates from the fourth district have informally suggested Dr. Dewey R. Powell as a successor to Doctor DeLappe; now, therefore, be it

Resolved, That the San Joaquin County Medical Society instruct its delegates to the Yosemite meeting to present to the House of Delegates of the California Medical Association the name of Dr. Dewey R. Powell for councilor from the fourth district; and be it further

Resolved, That the secretary of the San Joaquin County Medical Society be instructed to communicate at once with each county unit in the fourth district announcing Dr. Dewey R. Powell's candidacy and requesting its support.

It was moved the resolution be adopted. Carried.

The scientific program of the evening was then presented by Doctors Shipman, Pierson, Rogers, and Eloesser of San Francisco, who presented a *Symposium on Tuberculosis.* Doctors Shipman and Pierson discussed tuberculosis and its treatment from the medical end, and Doctors Rogers and Eloesser discussed it from the surgical end. The paper was discussed by Doctors Powell, Collis, Fitzgerald, Doughty, and the guest speakers.

President Broaddus announced that the next meeting would have a paper by Doctors Reed and Johnson of San Francisco on *Amebic Infections,* with discussions of materials. Doctor Broaddus then appointed a committee, composed of Doctors Gallegos, Doughty, and Kaplan, to further the nomination of Dr. D. R. Powell for councilor of this district.

There being no further business to come before the Society, Doctor Broaddus introduced several visitors and declared the meeting adjourned at 10:11 p. m. Refreshments were served.

G. H. ROHRBACHER, *Secretary.*

SAN LUIS OBISPO COUNTY

Report on activities of the Program Committee for the year 1934 is as follows:

At the January meeting, Dr. Dudley Smith of Oakland gave a talk on the *Surgical Conditions of the Rectum and Colon,* illustrating his lecture by lantern slides and demonstrating some of the instruments used. Doctor Ullmann was present and talked on matters of importance before the State Society.

At the February meeting, Dr. George K. Rhodes and Dr. Fred H. Kruse of San Francisco discussed the *Medical and Surgical Treatment of Peptic Ulcer,* illustrating the same by case histories and x-ray films.

In March the Society met at Atascadero and were entertained by Dr. G. W. Pierce of San Francisco, who spoke on *Burns and Their Treatment,* illustrating this talk with lantern slides.

In April, Dr. H. Jones of Los Angeles discussed the *Treatment of Fractures,* which he illustrated by x-ray films and lantern slides. He also exhibited apparatus which he uses in the treatment of fractures.

In May, Dr. Karl Meyer of the Hooper Foundation of the University of California was entertained by the medical society at the Motel Inn. The meeting later was adjourned to the High School, where Doctor Meyer spoke on *The Rise and Fall of Epidemics.* The public was invited to hear Doctor Meyer's talk, and about two hundred were present.

At the June meeting Dr. Vern Hunt of Los Angeles gave a talk on *Malignant Tumors of the Colon and Intestinal Obstructions.*

During the dinner Doctor Ullmann and Mr. Ben Read of the Public Health League addressed the meeting on the *Importance of the League to the Profession from the Economic and Legislative Standpoints,* resulting in a branch organization for San Luis Obispo County being formed.

In July, Dr. Sterling Bunnell of San Francisco spoke on *Fractures of the Hip,* illustrating the same by lantern slides, specimens, and instruments.

In August, Dr. Eric Larsen of Los Angeles discussed *Thyroid Disease,* differentiating between the different types. Doctor Langley of Los Angeles discussed *The Thyroid in Heart Disease.*

At the September meeting, Dr. Adolph Kutzmann of Los Angeles presented a discussion on *Lesions of the Urinary Tract,* illustrating the same with lantern slides, with lesions in abdomen, spine, and thorax.

In October, Dr. Stacey R. Mettier talked on *Classification of Anemias in General,* and Dr. Ernest Falconer, also of San Francisco, followed with a talk on the *Treatment of Secondary Anemias.*

No meeting was held in November.

In December the annual meeting was held at Paso Robles, with a dinner and dance for wives and guests of the members, a very pleasant evening being enjoyed.

ALLEN F. GILLIHAN, *Secretary.*

SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held in the Bissell Auditorium of the Cottage Hospital on Monday, March 11, at 8 p. m., Vice-President Gray presiding.

Doctor Gray called upon Doctor Hare, who introduced the speaker of the evening, Dr. George Thomasen, professor of surgery of the College of Medical Evangelists, Los Angeles. Doctor Thomasen's talk on surgery of the pancreas was extremely interesting and timely, and was discussed by Doctors Stone, Findley, McNamara, Sansum, Nuzum, Koefod, Henderson, and Kluss.

The application of Dr. Susanne Parsons for membership was read and upon balloting she was unanimously elected into the Society.

Doctor Evans then reported for the special meeting of the delegates at Los Angeles. This report was supplemented by Doctor Friedell, the other delegate, and it was moved, seconded and carried, that the report be filed. The secretary then read the final resolution as amended by the committee, which was adopted by the House of Delegates. After discussion it was moved, seconded and carried, that the Society endorse the action of the House of Delegates and that this resolution be attached to the minutes of this meeting.

It was then moved, seconded and carried, that the Publicity Committee give to the newspapers whatever they thought advisable regarding the meeting of the House of Delegates.

Doctor Gray reported for the Program Committee, stating that the program has been completed for the balance of the year, with the exception of the June and December meetings. He also reported for the Community Medical Service Committee, and stated that the dental society was desirous of uniting with the medical society, but that they, the dental society, were in favor of having the social worker collect all the fees and retain 10 per cent for operating expenses, as was the original proposal, rather than assessing the doctors so much each month. After discussion it was moved, seconded and carried, that the committee discontinue assessing the members of the medical society and that the committee collect all the fees, retaining 10 per cent for operating expenses and remitting the balance to the doctors who gave the service.

A communication from the Santa Maria branch of the Santa Barbara Medical Society, inviting the Society to attend a barbecue at Santa Maria on June 29, was read.

WILLIAM H. EATON, *Secretary.*

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SISKIYOU COUNTY

The regular meeting of the Siskiyou County Medical Society was held at the Weed Hospital, in Weed, on Sunday afternoon, March 17. It was decided to form an Auxiliary to the Society.

Dr. Victor Hart, who attended the meeting of the House of Delegates in Los Angeles as our representative, gave a report of the proceedings. There was marked objection to the right of the Board of Regents of the University of California to make appointments, they themselves being appointed by the Governor. There was also objection to the fact that the local managers (as described in the tentative draft), were not of necessity to be chosen from the local medical society and, therefore, not in perfect understanding of local state of affairs and practice. It was felt that the appointment of some old retired doctor, a stranger to the local problems, and not in sympathy with the local doctors, would be far from desirous. Another point that caused adverse criticism was the failure to insure farm hands. Much of our practice is derived from this source. And many of these men are employed year in and year out (not merely casual laborers).

A film, *Treatment of Injuries to the Extremities,* was shown. It was resolved that all who could get away would attend the meeting of the Shasta County Medical Society on Tuesday night, March 19, at which meeting our State President Doctor Toland, President-Elect Doctor Peers, and our State Secretary, Doctor Warnshuis, were to be present. Meeting adjourned.

* * *

On Tuesday night, March 19, eight members of the Siskiyou County Medical Society went to Redding (some of us driving as far as 140 mountainous miles, through the snow), where a very congenial and instructive meeting was held, followed by a very fine repast. It was well worth our time and effort, as we had the pleasure of meeting and hearing Doctor Toland and Doctor Peers. We take this opportunity to again thank the Shasta Society for its hospitality.

Our next meeting is to be held at the Yreka Inn, Yreka, on April 28, in the early afternoon.

LESLIE J. SEELEY, *Secretary.*

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SOLANO COUNTY

The Solano and Napa County Medical and Dental societies held a joint meeting in Vallejo on March 12. Guy Millberry, D. D. S., of San Francisco, and Dewey Powell, M. D., of Stockton were the speakers. Both spoke on the *Problem of Health Insurance.* Sixty attended.

A. E. CHAPPELL, *Secretary.*

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SONOMA COUNTY

The Sonoma County Medical Society held its regular monthly meeting on March 14 at Leggerini's in Santa Rosa, President F. O. Butler presiding.

An application in due form was received from Dr. R. L. Zieber of Santa Rosa.

Resolutions adopted by the House of Delegates were read. A report by Doctor Butler, delegate, was then made in detail. Doctor Rogers made a detailed report on some of the activities of the State Society.

The president then introduced Dr. John W. Green of Vallejo, who addressed the Society on the subject, *Acute Diseases of the Ear in Relation to the General Practitioner.* All present enjoyed Doctor Green's remarks and asked him many questions. A general discussion followed, and all present seemed pleased with the meeting.

W. C. SHIPLEY, *Secretary.*

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TULARE COUNTY

A special meeting of the Tulare County Medical Society was called on February 21 at 8 p. m. at Motley's Cafe for the purpose of reviewing the recent action of the Tulare County Board of Supervisors in authorizing an increase in salary to the county physician and the granting to him of the right to private practice outside of the County Hospital.

The secretary briefly outlined the pertinent facts as related to a group of doctors by Supervisor Patterson. Each member present was called on in turn to express an opinion. After thorough discussion the following resolutions were drawn:

WHEREAS, The Board of Supervisors of Tulare County, assembled in secret session on Tuesday, February 19, 1935, did authorize an increase in salary to the county physician from $4,000 to $4,200 yearly and in addition granted the county physician the right to care for private patients in other than the County Hospital; and

WHEREAS, Because of the secret session the taxpayers generally had no opportunity to voice their opinions on money expenditures as related to the management of the County Hospital; and

WHEREAS, Because of the secret session the members of the medical profession of Tulare County were given no opportunity to present their views or offer their recommendations; and

WHEREAS, It is the belief of the members of the medical profession that any action to combine the private practice of medicine with the management and care of county indigents is not for the best interests of the taxpayers who support that institution nor for the best interests of the patients in the institution; and

WHEREAS, The granting of and right to private practice by the Board of Supervisors is in direct contradiction to the action taken by the Board of Supervisors at open session on previous occasions; and

WHEREAS, No other county employees have been granted an increase in salary; and

WHEREAS, A competent medical director can be obtained for the present county physician salary stipulation or less; and

WHEREAS, The present salary stipulation is already above the average income for doctors in California; now, therefore, be it

Resolved, That the Honorable Board of Supervisors of Tulare County be respectfully requested to reconsider their recent action in this matter and to rescind the action taken in the meeting of February 19, 1935, leaving the salary and agreement stipulations of the county physician as they are at present, until such a time as a general increase in county employee salaries shall occur and until a more satisfactory solution of the policy with regard to the welfare of county indigents can be arrived at by mutual agreement of the medical profession and the taxpayers as represented by the Board of Supervisors; and be it further

Resolved, That a committee be appointed in each supervisorial district to keep in closer touch with the policies relating to the health and medical welfare of the people of Tulare County; that it be noted that this resolution was passed by unanimous vote, and that a copy of the foregoing resolutions be sent to each member of the Tulare County Board of Supervisors, to the newspapers of Tulare County, and to the Fresno *Bee,* and that wide publicity be given to this action.

In addition to a discussion of the Supervisors' recent secret session action, other matters pertaining to the County Hospital situation were also voiced. The view was general that a visiting staff should have access to the educational facilities offered by such an institution. The manner of staffing a county hospital is to be investigated, and a committee will then present plans to the Society for approval.

It was then moved that the chair appoint a committee to act as the nucleus for the formation of a political body which can keep in close touch with the policies relating to the health and medical welfare of the people of Tulare County. This committee is to have representative groups in each supervisorial district.

KARL F. WEISS, *Secretary.*

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VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held in the Ventura County Clinic Building on March 12, Doctor Strong presiding.

A communication from the Stanislaus County Medical Society in regard to a definite x-ray schedule was presented, but this was tabled until we have determined the progress being made on this matter by the State Association's X-Ray Committee.

A report on the special session of the House of Delegates was given by Acting Delegate Morrison. Doctor Ullmann stressed the more important points of this meeting. This was followed by a good discussion.

Doctor Coffey reminded the members of the good work being done by the Public Health League and asked that every one pay their 1935 dues promptly. Doctor Homer moved that we give $20 to this cause. Doctor Hendricks seconded the motion and it was unanimously passed. A. A. MORRISON, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (61)

Alameda County.—John Azevedo, A. Bradford Carson, Luke M. Hamilton, Helena Mathiasen, Charles C. Morison, Stanley R. Truman, George V. Vandevert.

Butte County.—Wenonah King.

Fresno County.—Richard H. Carter, Verne Gordon Ghormley, Raymond J. Van Wagenen.

Los Angeles County—

Franklin I. Ball
R. Allen Behrendt
Lewis T. Bullock
Hildreth M. Caldwell
Donald E. Dement
William D. Donoher
Anne Fairchild
Henrietta M. Johnson
Herbert J. Kirchner
Frank E. Kliman
Robert F. Knoll
Carl E. Krugmeier
Thomas J. Laughlin
F. LeGrand Noyes
Leon Rosove
David E. Rouse
Harold E. Sanford
Isami Sekiyama
Albert F. Stelhorn
Kenneth Townsend
Abraham Waxman
John W. Wilson
Maurice L. Young

Marin County.—Leonard H. Larsen.

Riverside County.—Franklyn D. Hankins, Robert B. Reid.

San Bernardino County.—Mary E. Beall, M. Antoinette Bennette, Harry S. Blossom, John J. Burby, John B. Tyrrell, Pearl S. Waters.

San Diego County.—James T. Milton.

San Francisco County.—Howard H. Dignan, Rafael D. Friedlander, Mervyn H. Hirschfeld, Norman C. Klotz, Colin C. McRae, John Robert Sullivan, Harold F. Unsinger, Horace A. Wald.

San Joaquin County.—Irving B. Thompson.

San Mateo County.—Ralph D. Howe.

Santa Barbara County.—Susanne R. Parsons.

Santa Cruz County.—Eugene E. Gloor.

Siskiyou County.—Edward F. Carlson.

Tehama County.—Donald E. Thompson.

Ventura County.—Lois C. Wyatt, Arlo A. Morrison.

Yolo-Colusa-Glenn County.—Leo A. Cronan.

Transferred (9)

Thomas C. Austin, from Kern County to Los Angeles County.

A. E. Chappel, from Napa County to Solano County.

W. M. Edwards, from Lassen-Plumas County to Marin County.

John P. Fabian, from Sacramento County to Butte County.

Donald C. Fowler, from Tulare County to Marin County.

Leonard H. Larsen, from Sacramento County to Butte County.

Wrenshall A. Oliver, from San Mateo County to San Francisco County.

Edward B. Radford, from Placer County to Contra Costa County.

Clarence E. Wells, from Fresno County to Tulare County.

Resigned (8)

Leo B. Auerbach, from Los Angeles County.
Clarence Crane, from Humboldt County.
F. W. Hodgins, from Alameda County.
Henry A. Johnson, from Los Angeles County.
Frederick B. Mandeville, from Alameda County.
Raymond St. Clair, from Alameda County.
F. S. Wright, from Alameda County.

In Memoriam

Parker, Peter James. Died at Pacific Beach, March 15, 1935, age 89. Graduate of Jefferson Medical College of Philadelphia, 1871. Licensed in California in 1886. Doctor Parker was a retired member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

✝

Shuman, Joseph Raye. Died at Los Angeles, March 10, 1935, age 54. Graduate of Gross Medical College, Denver, 1902. Licensed in California in 1919. Doctor Shuman was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Stice, Tyre Harrison. Died at Napa, March 9, 1935, age 66. Graduate of Cooper Medical College, San Francisco, 1894. Licensed in California in 1895. Doctor Stice was a member of the Napa County Medical Society, the California Medical Association, and the American Medical Association.

✝

Trewhella, James Saundry. Died at Los Angeles, February 11, 1935, age 65. Graduate of Northwestern University Medical School, Chicago, 1905. Licensed in California 1906. Doctor Trewhella was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Wheat, James Edgar. Died at San Fernando, February 9, 1935, age 75. Graduate of the University of Southern California School of Medicine, Los Angeles, 1900 and licensed in California the same year. Doctor Wheat was a member of the Los Angeles County Medical Association, the California Medical Association and the American Medical Association.

✝

Whitney, James Lyman. Died at San Francisco, March 12, 1935, age 54. Graduate of Harvard University Medical School, Boston, 1905. Licensed in California in 1907. Doctor Whitney was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Arthur Clarkson Smith
1882-1934

The Alameda County Medical Society, having lost one of its most valued members in the death, on November 25, 1934, of Dr. Arthur Clarkson Smith, offers its sincere sympathy to Mrs. Alga Hurd Smith, his widow, and Miss Alga Smith, his daughter.

In deference to the simplicity of Doctor Smith and his known aversion to form and ritual, this resolution is not offered in the customary manner, but it does, nevertheless, express the feelings of the entire membership of the society and will be so entered in its minutes.

Dr. Arthur Clarkson Smith was a member of a family whose valued services in public life won them a lasting place in public esteem. He chose to hide his light beneath the bushel of medicine and surgery, yet in the final analysis his works are indelibly recorded.

It is given to some men to write the account of their brief span in monuments of granite; to others, a chosen few, to write their account on the heart of humanity. The members of the Alameda County Medical Society consider it a privilege to have known and worked with "A. C." Smith.

His life was an inspiration to the younger members and a treasured experience to his colleagues. Of him it may truly be said, we shall not see his like again—doctor, scholar, humanitarian and man—Arthur Clarkson Smith, born in Oakland, 1882, graduated from the Oakland College of Medicine, 1906; staff member of Merritt and Providence hospitals, and, for twenty years, of the Alameda County Emergency Hospital; died, 1934.

E. N. Ewer
Frank Bowles
E. M. Lundegaard

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. PHILIP SCHUYLER DOANE President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

Come to Yosemite.—California's great medical convention this year on May 13 to 16 offers a rare treat in combined pleasures. May, in the Yosemite, is the year's loveliest month, the Ahwahnee, a superb setting for all the gay amenities that have been planned for your delight. There'll be dining and dancing, musicales and teas, cards and conversation, informal fun and stately ceremonies. No matter what your taste there's a ticket for it. Since in these days of severely slender budgets we must find all the fun we can as we fly, remember too, all the glorious offers of outdoor sports that wait for you there, riding, motoring, tennis, strenuous alpine climbing or gentle strolling along woody paths, and as each day ends, the famed fire-fall from Glacier's edge.

This is the California Medical Auxiliary's sixth annual meeting and a most important one. At our luncheons men of the profession nationally noted for their leadership will bring to you direct their messages. These are critical years in the development of medicine here as in the world over. The decisions of the profession in meeting the challenge of changing times are of vital concern to you. On the anvil of the annual convention they are hammered into shape. You can learn them there first hand. Your own Auxiliary is closing a year that has been a high point in achievement, an inspiration in vistas of service ahead, a fine and thrilling experience under dynamic leadership. Today's work is done through organizations. Come and help in this one which surely holds a claim on your loyalty. You'll find the full program of the Auxiliary, together with that of the California Medical Association, in other pages of this issue. Read them and come.

* * *

Highlights of the State Board Meeting.—The special session of the officers and board of the Woman's Auxiliary to the California Medical Association at the Lake Merritt Hotel in Oakland on February 15 was characterized by a fine efficiency that cleared the calendar of all unfinished business and introduced and completed much that was new. State president, Mrs. Philip Schuyler Doane of Pasadena, presided, and the following members attended: From Alameda County, Mesdames Thomas J. Clark, William H. Sargent, Robert T. Sutherland and Frank S. Baxter; from Santa Barbara, Mrs. H. E. Henderson and Mrs. Charles Sidney Stevens; from Mendocino, Mrs. Robert E. Gleason; from Contra Costa, Mrs. U. S. Abbott; from Sacramento, Mrs. Frederick N. Scatena; and from Los Angeles, Mrs. John V. Barrow and Mrs. Elmer Belt. County presidents, Mrs. N. N. Brown of Kern and Mrs. Manuel Fernandez of Contra Costa were also present.

Mrs. William H. Sargent, chairman of membership and organization, reported a total state membership of 1,079 and an expected increase to be shown in the spring reports. Several developing possibilities for new county units including one in Siskiyou, whose county medical society has written for information regarding the establishment of an Auxiliary there, give promise of an early organization. President Doane read a surprise telegram just received from Mrs. Chester J. Teass of San Luis Obispo County with the news of a reorganization meeting there set for March 9.

Public relations chairman, Mrs. John V. Barrow, told of the building of a Speakers' Bureau to supply lay organizations with able, authoritative lecturers for public health and medical programs. Several such speakers have already answered requests for talks and have been well received and thoroughly successful. Mrs. Frank S. Baxter, state *Hygeia* chairman, suggested a plan of increasing *Hygeia* subscriptions by enclosing an attractive and well-worded leaflet, describing the magazine, in the doctors' statements as they are mailed out each month.

Editor and publicity chairman, Mrs. Elmer Belt, reported the mailing of 1,100 copies of the new state paper, *The California Medical Auxiliary Courier*, in December. Printing costs were covered by advertisements and postage for those mailed individually to members throughout the state is to be paid by the

*As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

counties a cent and a half per copy. The editor announced an Easter edition to be off the press early in April.

A request from the National Auxiliary for an exhibit from California for the national annual convention to be held in Atlantic City in June was considered and it was decided to make a large pictorial map of the state showing the organized counties and their membership and other data of interest concerning them to be gathered by Mrs. Sargent, and items of historical and educational importance besides. The map will be made under the supervision of Mrs. Belt, chairman of exhibits, and placed on display at Yosemite, it is hoped, as well as at the national meeting.

The president reserved for the closing report that of the convention chairman, Mrs. Frederick N. Scatena. Mrs. Scatena has made several trips into the valley to arrange accommodations, assembly halls and all the other detailed requirements necessary for a large and active gathering. Mrs. Doane had come north a day early so that every item could be completed and ready for presentation to the board and had worked with Mrs. Scatena in an all day session on Thursday perfecting plans for work and play. The program presented was complete and excellently arranged and adjusted. Every member of the board spoke with enthusiasm over their fine work and skillful planning.

* * *

Another County Added.—It is with great pleasure that we announce the reorganization of the Woman's Auxiliary to the San Luis Obispo Medical Society, and welcome them into our state group. On March 9, Mrs. Chester J. Teass of San Luis Obispo invited the women of the county to her home and the formation of an Auxiliary there was the happy result of the meeting. With twenty-five doctors in their county medical association, this new unit has started with fourteen members signed and paid for and five other eligibles signifying their intention of joining at the next meeting. Nineteen makes a remarkable proportion for the county group at their opening occasion and continued success should flow from this early attainment. The new officers chosen for the county are: President, Mrs. Maude Gallup; first vice-president, Mrs. J. B. V. Butler; second vice-president, Mrs. Jens. W. Larsen of Paso Robles; secretary-treasurer, Mrs. Alynette Bateman. The first regular meeting has been set for April 2 when Mrs. Doane will be their guest of honor and speaker.

* * *

County Auxiliary Reports

Alameda County.—The regular February meeting of the Woman's Auxiliary to the Alameda County Medical Association was held on Friday the 15th at the Lake Merritt Hotel in Oakland. The luncheon which preceded the meeting was served in the hotel dining room overlooking the lake, and the Alameda Auxiliary had asked as their guests all the state officers and board who had come from seven counties for a special session of the board of the Woman's Auxiliary to the California Medical Association held that day in Oakland. There are on the state board four Oakland women: Mrs. Robert T. Sutherland, president of the Alameda Auxiliary and state chairman of public health activities; Mrs. Thomas J. Clark, finance chairman and president-elect of the California Medical Auxiliary; Mrs. William H. Sargent, chairman of membership and organization and vice-president of the state group, and Mrs. Frank S. Baxter, state *Hygeia* chairman.

Mrs. Sutherland presided and introduced Mr. Everett Foster, NBC baritone, who as guest soloist sang a group of four delightful ballads, with Mrs. Foster as piano accompanist. Mrs. Sutherland welcomed the visiting guests and asked Mrs. Philip Schuyler Doane, the state president, to introduce her board, which she did with wit and charming grace. Mrs. Doane then as the speaker of the day touched upon several of the pertinent problems facing the Auxiliary and suggested possible solutions for them. As a special feature for building and strengthening the public relations work, Mrs. Doane suggested to the Alameda Auxiliary the inauguration of a Public Health Institute Day, an occasion on which a number of outstanding speakers would present current public health topics of interest to the general public. Clubs and civic groups would be invited to coöperate and to attend as many of the lectures as they wished. After the guests had departed a general business session terminated the meeting.

Mrs. A. W. Henry, *Publicity Chairman.*

* * *

Los Angeles County.—An event eagerly heralded was that of the first meeting of the Auxiliary held in the Los Angeles County Medical Association building on February 26, attended by over one hundred and fifty members and presided over by Mrs. John V. Barrow, president. For many it was the first opportunity to view the beautiful quarters and the pleasure of meeting in such harmonious surroundings was everywhere apparent. Dr. Harry Wilson, Mr. Stanley Cochems and Mr. Cross were most solicitous in arranging everything for the comfort and convenience of the members. The 1934 year book, beautifully compiled by Mrs. Eliot Alden and her committee, made its initial appearance and was received with interest. Mrs. James F. Percy in a gracious speech presented to Mrs. Barrow the "latest thing in gavels" and judging by its streamline contour this was no exaggeration. Mrs. Philip Schuyler Doane expressed her pleasure that the meeting was being held in "our medical home" and commented on the fact that the Auxiliary membership had passed the five hundred mark.

Mrs. Barrow then introduced Mr. Ben Read, executive secretary of the Public Health League of California, a welcome and familiar figure at our meetings. He prefaced his remarks by threatening to hand in an application for associate membership. He outlined some of the impending public health measures to come before this session of the legislature. Among others he mentioned that the bill relative to the commitment of the insane was again before the legislature, and recalled to our minds the fact that it had been vetoed before as the result of pressure brought to bear by the fifty-eight sheriffs of the state. He admonished us to write our assemblyman in regard to Bill 188, designed to curb false advertising of drugs over the air.

Dr. Harry Wilson, president of the County Medical Association, recently returned from Chicago where he was chosen chairman of the Reference Committee of the American Medical Association House of Delegates, called in special session to consider social health insurance problems. He briefly discussed the survey made of the economic conditions in California in an attempt to determine if people are being denied medical care and if social insurance is a practical answer to the problems.

Dr. Alvin G. Foord, professor of pathology at the University of Southern California, gave us some very pertinent talking points to refute arguments against animal experimentation. He mentioned the progress medical science had made, effective only through this means, and explained the need of its use in diagnoses, for serums and vaccines, and its importance in fighting cancer. Doctor Foord told of the practical disappearance of such scourges as yellow fever, smallpox, and diphtheria in this country and of the lowered incidence of tuberculosis and tetanus, all of which diseases would reappear and flourish, the results of years of research being destroyed, should animal experimentation be banned. This was all graphically depicted by slides, Mrs. Foord assisting in operating the projector.

A new activity has been undertaken by Mrs. Barrow with the assistance of Mrs. Arthur Annis in organizing the assembly districts for the purpose of holding assembly teas designed to foster new interest

in the Auxiliary and to develop greater coöperation with the civic life of the community. Mrs. A. Brockway is the general chairman in charge of the teas, which will be given in the districts as they are organized and to which the wives of doctors will be invited regardless of whether or not they are Auxiliary members. Among the chairmen of the districts already formed are: Mrs. Arthur Annis, Mrs. V. Bonfiglio, Mrs. A. Brockway, Mrs. Harold E. Crowe, Mrs. Donald A. Charnock, Mrs. Jerry Lacoe, Mrs. George Maynard, Mrs. Robert Meals, Mrs. Joseph A. Polia and Mrs. R. L. Schulz.

Mrs. Harold E. Crowe,
Corresponding Secretary.

* * *

Orange County.—The Orange County Medical Auxiliary met in Anaheim at the home of Mrs. H. A. Johnston for their March meeting. Due to the absence of the president, Mrs. Harry Huffman, who could not be there, the vice-president, Mrs. D. C. Cowles, presided at the business session. Mrs. Dexter Ball introduced the speaker, Mona Summers Smith, of the Santa Ana Public Library staff, who discussed a group of plays now current in New York City. Among them were this season's production of "Romeo and Juliet," with Katherine Cornell in the leading rôle, "Escape Me Never," with Elizabeth Bergner, Noel Coward's "Point Valaine," with Lynn Fontanne, and "Within the Gates," starring Lillian Gish. Mrs. Smith concluded her program by reviewing the first scene of "Valley Forge," Maxwell Anderson's play that is proving one of the most popular of the year.

Assisting Mrs. Johnston as hostesses for the afternoon were Mesdames E. H. Kersten, H. D. Newkirk, C. S. O'Toole and G. A. Paige. Tea was served at the close of the program from a table prettily appointed in white and green. Mrs. D. C. Cowles and Mrs. K. H. Sutherland presided at the tea urns.

Mrs. K. H. Sutherland, *Secretary.*

* * *

Sacramento County.—The regular meeting of the Woman's Auxiliary to the Sacramento Medical Society was held at the home of Mrs. William K. Lindsay on Tuesday evening, February 18, with the president, Mrs. Frederick N. Scatena, presiding. Mrs. Scatena, who is convention chairman for the annual meeting of the State Auxiliary in Yosemite this May, gave a report on the plans for the convention and of the entertainment that is being planned for Auxiliary members and guests. There was brought before the meeting the need of a deserving woman for clothes and donations were asked for and are to be brought to the home of Mrs. J. T. Vance, who will make up a suitable box to be sent to her. At the close of the business session there was a social hour for bridge. The hostess, Mrs. Lindsay, was aided by Mrs. Lindsay, Sr., Mrs. Margaret Farrell, Mrs. J. F. Worley, Mrs. Floyd Schaap, Mrs. R. M. Wallerius, and Mrs. A. D. Phillips.

Refreshments were enjoyed from a beautiful tea table decorated with orange colored candles and calendulas.

Sarah L. Brendel,
Corresponding Secretary.

* * *

San Joaquin County.—The Woman's Auxiliary of the San Joaquin County Medical Society has met during the past year on the first Thursday of May, November, January, and March. With the exception of the luncheon at the Country Club all the meetings have been held at the homes of the members. The following activities have been the chief accomplishments of the year's work so far: (1) a committee checked the local registration lists and reminded by telephone all the doctors who had not registered, (2) about 1,000 form letters were sent out by the Auxiliary members to their friends urging their help in the defeat of the chiropractic and naturopathic propositions on the November ballot, (3) together with the San Joaquin Medical Society and the local health center, the Auxiliary sponsored bringing to Stockton for two weeks an exhibit entitled "The Marvel of Heredity," a part of the famous German Hygiene Museum of Dresden, Germany. This exhibit had been brought to the Century of Progress Fair in Chicago by Dr. Bruno Debhard. At least four thousand visitors attended the showing here. No admission was charged. Special credit for making the arrangements for bringing out the exhibit is due our secretary, Mrs. Ella B. Conzelman.

Mabel Jones Broaddus,
Publicity Chairman.

NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D....Associate Editor for Nevada

* * *

E. E. HAMER, Carson City President
R. O. SCHOFIELD, Boulder City.....President-Elect
C. E. SECOR, Elko.....First Vice-President
HARRY W. SAWYER, Fallon.....Second Vice-President
HORACE J. BROWN, Reno.....Secretary-Treasurer

WASHOE COUNTY

The Washoe County Medical Society held its regular monthly meeting at the State Building on March 12, Dr. Fleet Harrison of Minden presiding. The routine business was first considered.

Doctor Harrison, president pro tem, then called on the guest-speaker of the evening, Dr. Edward Records, dean of the Veterinary Department of the University of Nevada, who gave a very interesting talk on the *"Relationship of Tuberculosis in the Various Species of Animal and Man."* His talk was greatly appreciated by the members present and convinced them that the medical profession owed a great deal to scientific veterinary service.

Considering the necessity of food animals and fowl for man's sustenance, it has truly been a marvel of successful scientific achievement to note how these animals and fowl are rendered free from disease before being offered as food. Doctor Records dwelt upon the building up of foundation herds and how in the early days, the scientific inspection and diagnosis for tuberculosis in cattle was a thing unheard of. Now, before stock can be imported for foundation herd purposes, the animals must be thoroughly inspected and tested in the homeland, and after being received in this country are again tested and submitted to quarantine for a certain period before being offered for sale. This assures the health of imported stock. Doctor Records also recounted the work done by his profession in cleaning out bovine tuberculosis in various sections of the country and remarked that Nevada cattle are practically 100 per cent free from tuberculosis. One can realize the importance of this statement when it is known that there are certain areas in the United States in which both cattle and milk cows are largely infected. The importance of this relation to human health cannot be overestimated when it is considered that milk is a staple item of daily food. Statistics show that a large per cent of Old World cattle and milk cows are infected with tuberculosis and it is no stretch of the imagination to look back three or four decades and realize that this country received for residence quite a number of children with tuberculosis of the spine or hip, evidently the result of tubercular milk feeding.

Doctor Records also dwelt upon tuberculosis in swine and fowl. The safeguards in these animals was found by eliminating the old fowl from the barnyard, and the early marketing of pigs before tuberculosis developed. A vote of thanks was tendered Doctor Records for his excellent paper.

Thomas W. Bath, *Secretary.*

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American College of Physicians, Philadelphia, April 29-May 3, 1935. Mr. E. R. Loveland, 133 South Thirty-sixth Street, Philadelphia, Executive Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

Arizona State Medical Association, Phoenix, April 25-27, 1935. D. F. Harbridge, M. D., 15 East Monroe Street, Phoenix, Secretary.

California Medical Association, Yosemite National Park, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

Lane Medical Lectures.—The twenty-fifth course of Lane Medical Lectures will be delivered by G. V. Anrep, M. D., Sc. D., F. R. S., professor of physiology, medical faculty, Egyptian University, Cairo, Egypt, on the evenings of April 22, 23, 24, 25, and 26, 1935, at 8:15 p. m., in Lane Hall, Stanford University School of Medicine.

Professor Anrep will give the following lectures:

April 22.—Lecture I: The Proprioceptive Mechanism of Cardiovascular Regulation.

April 23.—Lecture II: The Central and Reflex Respiratory Regulation of the Heart Rate.

April 24.—Lecture III: The Coronary Circulation.

April 25.—Lecture IV: The Coronary Circulation.

April 26.—Lecture V: The Circulation in the Voluntary and Plain Muscles in Relation to Their Activity.

Professor Anrep will also give a lecture at Stanford University on Wednesday, April 24, 1935, at 4 p. m., on "Recent Advances in the Physiology of the Circulation."

Medical Broadcasts*

American Medical Association Health Talks.—The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4 to 4:15, central standard time.

* * *

San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of April is as follows:

Tuesday, April 2—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Sickness Insurance.

Tuesday, April 9—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: What Is Cancer?

Tuesday, April 16—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Fatigue.

Tuesday, April 23—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: The House Fly.

Tuesday, April 30—KJBS, 11:15 a.m., and KFRC, 1:15 p.m. Subject: Infection and Immunity.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of April is as follows:

Saturday, April 6—KFI, 9 a. m. Subject: The New Frontier.

Saturday, April 6—KFAC, 10:15 a. m. Subject: Your Doctor and You.

Tuesday, April 9—KECA, 11:15 a. m. Subject: The New Frontier.

Saturday, April 13—KFI, 9 a. m. Subject: The New Frontier.

Saturday, April 13—KFAC, 10:15 a. m. Subject: Your Doctor and You.

Tuesday, April 16—KECA, 11:15 a. m. Subject: The New Frontier.

Saturday, April 20—KFI, 9 a. m. Subject: The New Frontier.

Saturday, April 20—KFAC, 10:15 a. m. Subject: Your Doctor and You.

Tuesday, April 23—KECA, 11:15 a. m. Subject: The New Frontier.

Saturday, April 27—KFI, 9 a. m. Subject: The New Frontier.

Saturday, April 27—KFAC, 10:15 a. m. Subject: Your Doctor and You.

Tuesday, April 30—KECA, 11:15 a. m. Subject: The New Frontier.

Pacific Coast Surgical Association.—Item from San Francisco *Examiner* follows:

"Dr. Harold Brunn of San Francisco was elected president of the Pacific Coast Surgical Association at the organization's tenth annual meeting at Santa Barbara. Other officers named included Dr. Edward L. Gilcreest, San Francisco, reëlected secretary-treasurer. The next annual meeting will be held in February, 1936, at Del Monte, and will be preceded by clinics in San Francisco."

Pamphlets on Nursing Schools.—Three pamphlets, "So You Want to Be a Nurse," "How to Choose a Nursing School," and "When You Are a Nurse," have been prepared by the Nursing information Bureau of the American Nurses Association, 50 West Fiftieth Street, New York, coöperating with the N. L. N. E. and the N. O. P. H. N., and are ready for distribution. Their price is $1.25 a hundred, or $12.50 a thousand, in any desired combination of the three. They will be purchased in large numbers, we hope, by state nurses' associations, state leagues, and state boards of nurse examiners, and distributed by them through whatever channel they may determine to individuals as well as to high schools, libraries, Y. W. C. A.'s, vocational counselors and other interested groups.

American Association on Mental Deficiency.—The annual meeting of the American Association on Mental Deficiency will be held at the Hotel Palmer, Chicago, on April 25, 26, and 27. The Thursday and Friday sessions will be devoted to studies on Mongolism, birth injury as an etiological factor in mental deficiency, mental disorders in mental deficiency, the problem of sterilization, defective delinquency and its relation to penal institutions, community supervision of the paroled mental defective, and newer methods in institutional training for community life. The Saturday session, on April 27, will be devoted to the sociological, psychological, and the special educational aspects of mental deficiency. Physicians are cordially invited to attend these sessions. Complete data on the program may be obtained from the secretary, Dr. Groves B. Smith, Godfrey, Illinois.

Xth International Congress of the History of Medicine.—This will be held in Madrid, September 23 to 29, 1935, under the patronage of H. E. the President of the Spanish Republic and under the auspices of the National Academy of Medicine.

All those who will collaborate in the congress are kindly asked to send papers of their communications before June 1, 1935. The papers must be sent to the Scientific Secretary of the Congress, which summary (typewritten, and one copy) may not exceed one page in "octavo" (some four hundred words). All those summaries received in due time at the Scientific Secretary's office of the congress will be published in a booklet and handed over to congressists before the official inauguration of the congress.

The following five languages, in alphabetical order, are considered official languages of the X. International Congress of the History of Medicine: English, French, German, Italian, and Spanish.

Adhesion-papers, fees (check, money order) and all correspondence must be sent to Secretary of X. International Congress of the History of Medicine, Palacio de la Academia Nacional de Medicina, Calle de Arrieta, número 12, Madrid, Spain.

American Institute of Tropical Medicine.—The important influence that tropical diseases and tropical medicine have on the destiny of all mankind, will be considered at the first annual meeting of the American Institute of Tropical Medicine in New York City on Tuesday, April 16. Dr. Alfred C. Reed of the Pacific Institute of Tropical Medicine in the University of California, who is a member of the Academy's Council, Dr. C. A. Fofoid, chairman of the department of zoölogy and a charter member of the academy, and other distinguished members of the University of California faculty are expected to attend the meeting.

The Academy was organized at a meeting in Washington last year, called by the Leonard Wood Foundation for the study of leprosy. It was determined that, if the nations of the world are going to develop their export markets, they must look to the 1,600,000,000 people who make up the populations of the tropical countries. These people for the most part, possess very little in the way of manufactured goods and have no modern water supplies or sewage disposal systems, it was pointed out. They are potential customers for everything regarded as necessities by more favored peoples, but they do not have the funds with which to purchase such supplies. Their earning power and living standards are at a pitifully low stage because working conditions are poor and because many in these populations are victims of undernutrition, malnutrition and other diseases.

If the wages of these hordes of people could be increased by but a penny a day, their purchasing power would increase to $16,000,000 every day of the year, declares a statement issued by the Academy. A two cents a day increase, the price of a local postage stamp, would bring additional buying power of $11,680,000,000 a year. But even to attain this slight advantage, fundamental biologic laws must be taken into account. Health must be improved steadily through the application of existing knowledge and through new discovery.

Only in tropical countries can the world look for large expansion in the world trade, but the question of health must be paramount to any trade consideration.

The statement calls attention to the recognized work of the Pacific Institute of Tropical Medicine in the development of tropical medicine in the United States, together with Tulane University in New Orleans, the Department of Tropical Medicine at Harvard, the School of Tropical Medicine at Columbia University, the University of Puerto Rico in San Juan and the Gorgas Memorial Institute in Panama.

At the New York meeting the question of developing a non-medical foundation for tropical medicine will be discussed.

Closed Schools of Nursing.—The National League of Nursing Education reports that seventy-four accredited schools of nursing closed during 1934, leaving the total still open, 1,509. Some of these will be closing during 1935, for a number of them are thinking seriously about doing so.

Southern California Medical Association. — The Southern California Medical Association will meet at Arrowhead Springs Hotel May 3 and 4.

The program will be headed by G. V. Anrep, professor of physiology at the Egyptian University at Cairo, Egypt, who will lecture on "Coronary Circulation."

Others on the program who will give papers are as follows:

The Blood Picture in Hodgkins' Disease and Polymyositis with Special Reference to Eosinophilia, by H. M. Walton, Loma Linda.

Treatment of Gonorrhea—Franklin Farnum, Los Angeles.

Mucous Colitis—Harris Garcelon, Arrowhead Springs.

Endometriosis of the Appendix: Cysticercus Cellulosae—A. M. Moody, San Francisco.

Hypoglycemic Headache—Percy A. Gray, Santa Barbara.

Studies in Peripheral Vascular Disease — Albert H. Elliott, Santa Barbara.

Intravenous Urograms — Walter Pritchard, San Bernardino.

Spinal Anesthesia by A. D. Neubert, San Bernardino.

Depressed Skull Fractures: Clinical and Experimental Study—Mark A. Glaser, Los Angeles, and H. M. Beerman, Los Angeles.

Surgical Treatment of Chronic Empyema—John C. Jones, Los Angeles.

Some Notes on Malignancy of the Heart—Joseph A. Pollia, Los Angeles.

Management of Alcoholism—Harry H. Wilson, Los Angeles.

San Diego International Exposition. — The following announcement is made:

The skill of ancient Peruvian surgeons is revealed in an intriguing display in the Palace of Science of the California Pacific International Exposition, which opens May 29 in Balboa Park.

One phase of operative surgery, trephining, or removing a piece of bone from the skull, was performed by these aboriginal surgeons with repeated success.

"The reason for performing the trephining operation may have been in some cases ritualistic, in others practical, or both elements may have been present in the same instance," declared Malcolm Rogers, director of the Palace of Science, where he has assembled numerous prehistoric skulls taken from excavations in the Nasca region and other parts of Peru.

"The frequency with which warriors sustained head wounds in the form of depressed fractures could have well provided the aboriginal surgeons with ample material for experimentation, and also could have given them a definite stimulus to the development of a successful technique in performing the operation. Successful trephinings must have often brought back to normal, warriors and victims who were suffering from mental derangements due to the impinging of some bone fragments on the cortex of the brain," asserted Mr. Rogers.

"A comparison between the Peruvian skulls on display here, and the medical records of the Civil War, would tend to indicate that the ancient Peruvian surgeons were more successful in trephining than the army surgeons during the Civil War," he concluded.

Also included among the skull exhibits is one with a bandage in position, as left by one of the olden surgeons. The roll is cotton gauze and resembles modern surgical gauze in texture. It was fastened with cords of wool made from the Peruvian camel.

American Social Hygiene Association.—The association's annual meeting, held at the national offices, was well attended and a most enjoyable occasion. As announced previously in the "News," informal conferences were held in the morning, afternoon, and at luncheon, with discussion of such subjects as: What Is Desirable Information to Give in a Talk to a Group Such as a Parent-Teacher Association? Emergency Relief Treatment of Syphilis; Social Hygiene Objectives, and others.

The business session convened at 4 p. m., with Doctor Keyes presiding. Reports from the various committees were presented, work for the past year reviewed, and future activities discussed. Officers for 1935 were reëlected as follows:

President, Edward L. Keyes; vice-presidents, Eugene L. Bishop, Roscoe Pound, Ray Lyman Wilbur, Mary E. Woolley; treasurer, Timothy N. Pfeiffer; secretary, Mrs. Henry D. Dakin; members of the Board of Directors for 1935-1937, Robert H. Bishop, Jr., Norman F. Coleman, Timothy N. Pfeiffer, John H. Stokes, C.-E. A. Winslow, Kendall Emerson, A. J. Chesley.

A pleasant reception and tea served by the staff followed the adjournment of the business meeting, and the day closed with an informal dinner meeting at the Stockholm Restaurant, when further discussion of social hygiene matters took place.

Drug Vendors Still Trying to Sell Worthless Cure-Alls.—Patent medicine vendors still take advantage of the human desire for a simple remedy for all ills. Their "cure-alls" still appear in the Food and Drug Administration's reports of seizures. In the January list the inspectors reported a typical concoction of this class, "Marleo the All-Purpose Ointment." Seized at Pocatello, Idaho, it was labeled with broad claims such as were common before the days of the Food and Drugs Act: "Defies infection. Recommended for blood poison, infections, removing splinters, stepping on rusty nails, dog bites, croup, bronchitis, swollen glands, sore throat, rheumatism, lumbago, eczema, piles, boils, burns, warts, varicose veins, old running sores, etc." These claims, the Food and Drug Administration alleges, are false and fraudulent.

The following products also were seized for the false and fraudulent claims noted: "Gosewich Garlic Tablets" for high blood pressure, rheumatism, arthritis, poor circulation, asthma, kidney trouble, intestinal disorders, and sleeplessness; "Mastin's Vitamon Tablets" for anemia, nervous deficiency, malnutrition, loss of appetite, physical breakdown and run-down conditions; "Okasa Silver" and "Okasa Gold," rejuvenation" preparations for men and women; "Zo-ro-lo," a mixture designed to aid nature in the treatment of many ailments," and "Scott's Nose and Throat Drops" for catarrh and hay fever. One lot of deteriorated anesthetic ether was located and destroyed. Although many hundreds of cans of anesthetic ether are analyzed annually by the Administration's chemists, substandard ether is now rare. . . .

The first of the Federal Government's prosecutions of manufacturers and distributors of alcoholic candies was closed on January 15, when Irving Levine and Morris Singer were fined a total of $208 in federal court at Brooklyn, New York, following their plea of guilty of violation of the Food and Drugs Act. Operating as the Romaine Candy Company and the Irving Candy Company, Levine and Singer had shipped candy with liquid alcoholic centers to Philadelphia, the goods beings sold in cheap restaurants and low-grade grocery and candy stores to school children. The principals in this racket did not, apparently, realize that the repeal of prohibition legislation did not nullify the provisions of the Federal Food and Drugs Act, which twenty-nine years ago foresaw the dangers of the inclusion of alcohol in confectionery. Other persons involved in similar violations in the central part of the country will be brought to trial as soon as can be arranged. . . .

CORRESPONDENCE

Concerning postconvention rates at Yosemite.

March 20, 1935.

To the Secretary:—It has been decided to offer those who attend the medical convention the privilege of staying on at the convention rates until May 22. Of course it is not necessary that they occupy the same accommodations as they use during the convention period, as they may change to any type they desire. We will probably have all types available after the convention crowd has departed.

We would appreciate it very much if you would run a publicity flash in your publication outlining this offer.

Sincerely,

Stanley E. Plumb,
Traffic and Advertising Manager.
Yosemite Park and Curry Company.

Concerning proposed legislation dealing with unethical advertising.

To the Editor:—Herewith I am submitting for your information the following resolution which was adopted at the last meeting of the Los Angeles Society of Ophthalmology and Otolaryngology:

Whereas, The Council of the California Medical Association at its meeting of December 22, 1934, approved a resolution asking California state examining boards to take steps to secure legislation that would do away with unethical advertising; and

Whereas, Amendments have been prepared by the State Attorney General's office which would aid in the attainment of that end and;

Whereas, Such amendments are needed to do away with price baiting; therefore be it

Resolved, By the Los Angeles Society of Ophthalmology and Otolaryngology, that this society approves in principle the proposed amendments and recommends to the state examining boards and to the State and County Medical Associations that an earnest effort be made to secure the enactment of such much needed legislation.

Yours truly,

Pierre Viole, M. D.

Concerning malpractice defense rendered through the Medical Society of the State of California. A letter of appreciation.

March 19, 1935.

To the Secretary:—I wish at this time to express my appreciation for the services which the Medical Defense Fund, through W. M. Rains, has recently rendered to me. Mr. Rains is a master in his profession and handled his part of this case with credit both to himself and the physicians of this state.

Yours truly,

(Signed) Horace F. Pierce.
1421 Chapala Street, Santa Barbara.

Concerning the session of the American Urological Association: Meeting in San Francisco (June 25-28, 1935).

To the Editor:—Plans are under way for a most successful meeting of the American Urological Association which will be held jointly with the Western Branch Society in San Francisco this summer. The Committee on Arrangements is working very hard and the coming meeting promises to be one of the best that the Association has ever held. Professor Hugh Hampton Young of Johns Hopkins University has been selected to deliver the Ramon Guituras lecture. He has selected as his topic "The Abnormalities and Plastic Surgery of the Lower Genito-urinary Tract." Professor Young is one of the foremost urologists in the United States and has done much to advance American urology and to place it in the foreground.

No one is more qualified to speak on this interesting subject.

In former years the Guituras lecture has been delivered by specially invited distinguished foreign guests. In 1928 Dr. Hans Wildbolz of Berne, Switzerland, delivered a very instructive lecture on renal tuberculosis; in 1929 Professor Alexander von Lichtenberg of Berlin spoke on kidney and ureteral lesions secondary to adnexal disease; in 1930 Dr. Edmond Papin of Paris elucidated the present concept of conservative operations of the kidney and in 1931 Mr. Frank Kidd of London chose for his topic "Acquired Renal Dystopia or Movable Kidney." Professor Young is the first American urologist to whom the American Urological Association has conferred their greatest honor—the Ramon Guituras lecture. This honor has been rightfully earned by Professor Young, as he has contributed largely to the study of diseases of the genito-urinary tract, has devised numerous new operative procedures, discovered new antiseptic medicaments and has instituted many new methods of treatment. All members of the California Medical Association who are interested in urology are cordially invited to attend this meeting as guests, at which they will have the opportunity of hearing Professor Young.

The scientific sections will be held in the world-famed Palace Hotel on June 24 to 27, 1935, inclusive. On June 28 the Western Branch Society will convene in scientific session in which prominent urologists of the western hemisphere will participate. On Saturday, June 29, members attending the congress will have an opportunity to participate in dry and operative clinics held across the bay in the Highland Hospital in Oakland.

Due to its geographical position, to its great distance from the eastern and middle western medical centers, San Francisco rarely has the opportunity of actually having a national urological meeting. It is well that the medical men of this state interested in urology should plan their vacations in order to attend the coming meeting of the American Urological Association which will be held in San Francisco this summer.

CHARLES P. MATHÉ, *Chairman,*
Publicity Committee.

Concerning exhibits on syphilis and gonnorhea.

To the Editor:—We are attaching an announcement which we believe will be of interest to your readers, and shall appreciate your making the contents known to them.

From time to time we shall take pleasure in sending you other information concerning our literature and facilities which may be of assistance, either in the form of special announcements as in this instance, or through the *Social Hygiene News.*

Please let us hear from you at any time when we may be of service or assistance.

Sincerely yours,

THE AMERICAN SOCIAL HYGIENE ASSOCIATION.

* * *

The American Social Hygiene Association announces miniature editions (8½ x 11 inches) of two exhibits, namely:

1. *The treatment of syphilis,* shown in the American Medical Association's scientific exhibit in Cleveland last June. The exhibit includes twenty-four charts made from a study of 8,000 cases at Johns Hopkins University, University of Michigan, The Mayo Clinic, University of Pennsylvania and Western Reserve University in coöperation with the United States Public Health Service. Price, 30 cents a set, $3 a dozen sets, postpaid.

Special statements by Doctors Stokes, O'Leary, Wile, Moore and Cole, regarding the treatment of syphilis, have been prepared to accompany this exhibit. The price for this collection is 10 cents a set, 80 cents a dozen sets, postpaid.

2. *Gonorrhea in the male,* also shown as part of the scientific exhibit of the American Medical Association, a few years ago. This exhibit includes ten charts, prepared by Dr. Edward L. Keyes, regarding the diagnosis and treatment of acute and chronic gonorrhea. Price, 10 cents a set, 80 cents a dozen sets, postpaid.

These charts may also be had in the form of lantern slides. Thirteen slides, including five drawings in color. Price $8 per set, or available for rental at $1 per day while in the hands of consignee, plus transportation charges.

This material should be useful in a variety of ways as, for example:

1. *For the instruction of medical students.* It would be advantageous to place a copy of these handy exhibits in the hands of each senior medical student, or at least to display the exhibit for students to study.

2. *For talks to medical societies.* For this purpose the small charts may be set up as an exhibit or lantern slides could be made of each chart.

3. *For instruction of nurses, social workers and others.*

Concerning hospital service insurance bills.

March 22, 1935.

To the Editor:—As a delegate to the recent meeting of the House of Delegates at Los Angeles, I received a series of bulletins concerning hospital service insurance bills from an organization entitled "The Associated Hospitals of California." Since similar bulletins were circularized among all the members of the California Medical Association attending the special meeting and since they contain certain misstatements concerning alleged inactivity of that association in rendering certain information I am sending this letter to you for publication.

1. The Hospital Association alleges that the California Medical Association has not given a decision as to "what is involved in so-called practice of medicine in x-ray rooms." The very fact that the California Medical Association has a section on radiology affirms this belief that such is the practice of medicine; therefore, the hospitals have received their answer long since. The preparation of films is part of the practice of radiology; since the latter is definitely the practice of medicine, the preparation of films constitutes part of the practice of medicine.

2. It is alleged that "Hospitals will have to separate the professional portion of the work of the roentgenologist . . . from the purely technical or hospital service. This can be done very readily and will be done by the California Medical Association." We feel sure that the California Medical Association and every other intelligent group that deals with public health will oppose any plan which aims at separating any branch of medicine into technical and professional portions. The State Board of Medical Examiners, as long ago as 1925, ruled that "the examinations of laboratories of clinical pathology and radiology constitute integral factors in the diagnosis of disease; for example, a Wassermann test or the microscopic examination of a tumor may be more essential in a diagnosis than the palpation of the pulse or the examination of the tongue, both of which are construed as the practice of medicine. This board believes that there is no argument regarding this question."

Again, the "Painless Parker" decision decided that the technical part of a professional service cannot be separated from the professional part of this service. If hospitals were permitted to separate one branch of medicine into technical and professional portions, it could be a short step to separating many other branches of medicine (especially surgery and gynecology) into technical and professional portions.

The proposed hospital service insurance bills purport to provide not only hospital services (which we commend) but also "technical x-ray service and other technical-medical laboratory services." These bills are thoroughly dangerous and misleading in their present form and should not be passed.

L. H. GARLAND, M. D., *Secretary,*
Pacific Roentgen Club.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 4, April 1910

From Some Editorial Notes:

Committee on Arrangements. — The Committee on Arrangements for the coming meeting of the State Society—the fortieth annual meeting—announce that their plans are practically completed. As already stated in the *Journal,* the Hotel Sacramento is to be the headquarters, and members should make their reservations as early as possible.

* * *

How It Has Happened.—The Council of the State Society was not in any way a party to this appropriation of the register and directory by Mr. Henry Kaplan of the Kaplan Medical Publishing Company. . . . And so the matter stands. Mr. Kaplan has clearly violated his contract with the Society, has told the House of Delegates most impudently that he will pay no attention to the wishes of the Society and that he will do what he pleases with the property of the Society. . . . But it is up to the members of the Society to determine whether they shall give away their property or keep it in their own hands.

* * *

Lest We Forget.—This is just to remind you that we have in the office a department of exchanges and locations which is entirely at your service; at the time of writing there are a number of excellent openings for young and energetic physicians. . . . Almost every month, too, there are advertisements of locations or equipment for sale, and if you contemplate a change it will pay you to look through the *Journal* carefully every month.

From an article on "Report of One Hundred Radical Mastoid Operations" by Cullen F. Welty, San Francisco.

In the surgery and after treatment of one hundred radical mastoid operations for chronic suppuration of the middle ear, it is quite natural to have some definite opinion. In the first place, as to the advisability of the operation in selected cases; secondly, as to what may be accomplished by this radical procedure; thirdly, the danger of the operation, in jeopardizing the life of the patient. . . .

From an article on "History of a Lawsuit for Alleged Malpractice" by Henry J. Kreutzmann, M. D., San Francisco.

The Council of the Medical Society of the State of California has wisely resolved to create a medical defense department; at the next meeting of the Society this action by the Council has to be sanctioned by the members. Few members, possibly, realize the importance of this matter, and in order to show to what an extent upon the most flimsical pretext a medical man may be subjected to expense of money, to waste of time and energy, to worry (worst of all!), the following "history" is written. . . . I have learned from this experience! I have never since tied myself to any absolute diagnosis or any definite operation. I tell the people now that there is a condition present, may be a fibroid of the uterus, may be a cystic ovary, which necessitates an operation in my opinion; it has to be left entirely to my judgment, what I am going to do at the time of operation. . . .

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section Page 11)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

Reports from the office of the Secretary of State relate that Percy Purviance, D. C., who, according to the records of the Board of Medical Examiners, has operated the Berkeley School of Chiropractic and the Golden Gate College of Chiropractic, recently added more schools to his list when on December 28, 1934, he incorporated the Mount Vernon Chiropractic College, Corporation No. 160888, and on January 14, 1935, incorporated the International University of Naturopathy and Chiropractic, Corporation No. 161070, capital stock $100, divided into one hundred shares of $1 each. The records indicate that both of these corporations state among their purposes is "to give diplomas." It is evident that legislation passed in 1927, 1929 and 1931, attempting to regulate the incorporation and operation of degree-conferring institutions, which have neither physical equipment nor financial responsibility, has proved ineffective.

The attention of the Board of Medical Examiners was recently directed to the advertisement of the Reeves Foundation, announcing the manufacture and sale of a remedy for stomach ulcers, duodenal ulcers, etc. Answer to this advertisement is reported to be productive of a booklet and an affidavit. The latter the recipient is assertedly requested to sign before a notary public, stating that the condition of the sufferer has been diagnosed by a doctor as being one of the maladies mentioned in the circular, because the "Foundation" claims they do not wish to sell the remedy excepting for the specified troubles.

The lucrative practice of Señora Angelina was recently interrupted by her conviction in San Diego of a charge of violation of the Medical Practice Act. According to her business card, she is a specialist in women's diseases, cancers, ulcers, tumors, fistulas, etc. She was in the United States on a temporary permit from Mexico. After being found guilty, she was sentenced to ninety days in the county jail, suspended on condition she leave the United States on or before March 4, 1935, and not return.

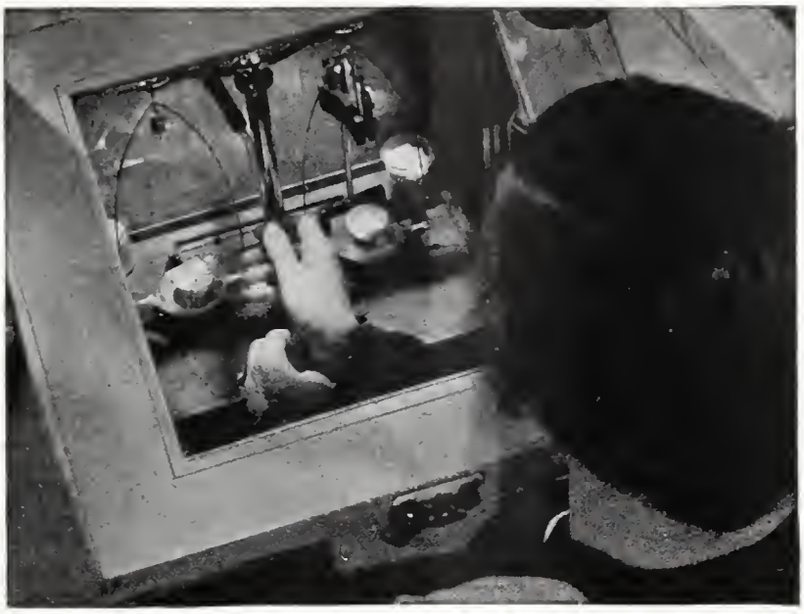
On February 1, 1935, the Appellate Court, Southern District, reversed the judgment of the Board of Medical Examiners, entered February 5, 1930, revoking the license of Roy L. Lanterman. Appeal has been filed.

Complaint was recently filed with the Board of Medical Examiners that William Victor had charged an elderly man $87.50 for a small package of pills, labeled "Okasa," which are assertedly sold by the drug trade for $5 per box. Victor, according to the report, was charged with petty theft and it is said that the court ordered him to make restitution.

"Dr." W. R. Robson, falsely claiming graduation from the University of California Medical School, was recently reported as traveling through New Jersey, posing as an eye doctor. He is described as a man sixty-seven years of age, height 5 feet 9 inches, weight 170 pounds, nationality Scotch.

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section Page 13)



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The Appendicitis Record for 1932 (By Frederick L. Hoffman, LL. D.).—The appendicitis death rate of American cities for 1932 shows a measurable reduction compared with the maximum rate reached in 1930. In that year the rate was 18 per 100,000 against a rate of 13.3 in 1910. In 1931 the rate had been reduced to 17.4 and was further reduced to a rate of 15.7 in 1932. These are the rates for sixty cities which for 1932 had a combined population of nearly 29,000,000. The details of this record are shown in the table given below.

TABLE 1.—*Deaths from Appendicitis—1910-1932*

Year	No. of Cities	Population	Deaths	Death Rate per 100,000
1910	60	18,656,436	2,480	13.3
1911	60	19,118,117	2,616	13.7
1912	60	19,569,879	2,712	13.9
1913	60	20,040,600	2,818	14.1
1914	60	20,503,331	2,948	14.4
1915	60	20,965,052	3,042	14.5
1916	60	21,426,774	3,175	14.8
1917	60	21,888,494	3,167	14.5
1918	60	22,330,216	2,907	13.0
1919	60	22,811,937	3,114	13.7
1920	60	23,275,106	3,644	15.7
1921	60	23,752,405	3,899	16.4
1922	60	24,229,704	3,936	16.2
1923	60	24,707,003	4,196	17.0
1924	60	25,184,302	4,338	17.2
1925	60	25,905,493	4,430	17.1
1926	60	26,138,900	4,653	17.8
1927	60	26,616,199	4,668	17.5
1928	60	27,333,472	4,837	17.7
1929	60	27,570,802	4,973	18.0
1930	60	27,995,351	5,049	18.0
1931	60	28,452,894	4,953	17.4
1932	60	28,923,952	4,528	15.7

A more elaborate comparison is shown for 177 American cities showing for 1932 the following results: The combined rate had been reduced from 17.9 per 100,000 in 1931 to 16.6 in 1932. The actual fall in the number of deaths from appendicitis in these cities was from 7,570 in 1931 to 7,136 in 1932, a gratifying indication of progress in the treatment of appendicitis on the one hand and a possible decline in local incidence on the other. The rate increased in eighty-one cities, decreased in ninety-two and remained the same in four. The combined population of these cities in 1932 was 43,000,000.

The highest rate of the cities under review was returned for Salt Lake City or 46.9 per 100,000, and the lowest rate for Union City, N. J., or 1.5, aside from three cities in which no deaths were reported for 1932, or respectively, Bethlehem, Pa.; Cicero, Ill., and Fresno, Calif. There were fourteen cities in 1932 where the rate exceeded thirty per 100,000, arranged in the order of their importance in the table given below.

Cities with Excessive Appendicitis Death Rates—1932

	Rate Per 100,000
Salt Lake City	46.9
Lexington, Ky.	42.9
Oak Park, Ill.	40.4
Nashville, Tenn.	39.0
Little Rock, Ark.	38.3
Portland, Me.	38.0
Memphis, Tenn.	37.4
Wheeling, W. Va.	35.0
El Paso, Tex.	34.3
Greensboro, N. C.	33.7
Jackson, Mich.	33.5
Madison, Wis.	32.7
Savannah, Ga.	31.6
Dallas, Tex.	30.1

Among cities with unusually low rates the following may be mentioned:

Cities With Low Appendicitis Death Rate—1932

	Rate Per 100,000
Union City, N. J.	1.5
Altoona, Pa.	2.3
Salem, Mass.	2.3
Akron, Ohio	3.0
Topeka, Kan.	3.0
Medford, Mass.	3.1
Mount Vernon, N. Y.	3.1
Pasadena, Calif.	3.6
McKeesport, Pa.	5.3
New Rochelle, N. Y.	5.3



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No satisfactory explanation can be given for these extraordinary differences which, however, are maintained from year to year with approximate consistency. No thorough study of the geographical incidence of appendicitis has ever been made for this country and no detailed examination of all the facts that bear upon the problem has been attempted. Regardless of its practical importance appendicitis still continues to be neglected as a public health problem. In 1931 the number of deaths from appendicitis in the United States registration area was 18,113, equivalent to a death rate of 15.2 per 100,000. When that rate is applied to the total population of continental United States the annual mortality is approximately 20,000. This compares with a rate of 7.2 per 100,000 for England and Wales. For the state of New York the average appendicitis death rate 1926-30 was 15 per 100,000, increasing to 15.7 in 1931. According to preliminary reports for 1932 the appendicitis death rate for 1932 was 14.8. For urban New York, exclusive of New York City, the average rate has been 20.4 for the period 1926-30, and 20.2 in 1931, while for rural New York the average rate was 3.6 against 5.3 for 1931. It is explained in the annual report of the State Health Department for 1931 that "The striking disparity in the urban and rural rates is due in large part to the fact that many residents of rural districts go to city hospitals for treatment, the deaths which occur among them being recorded in the places in which the hospitals are located. When correction is made for this factor the urban rate in 1931 is reduced from 20.2 to 15.9 and the rural rate increased from 5.3 to 13.4."

The appendicitis death rate among males is consistently higher than among females. For England and Wales in 1931 the male death rate for appendicitis was 8.4 per 100,000, while the rate for females was only 6.1. This disparity in rates has existed for many years and no explanation has been forthcoming as to the probable reasons for the difference. I give below the death rate by ages for males and females and both sexes combined for New York, separating New York City from the rest of the state, giving the returns for 1931 for purpose of illustration. It shows for New York City the highest death rate for both males and females at ages 65-74, while in up-state New York the male death rate was highest at ages 55-64, and the female rate at 75 and over.

Appendicitis Mortality in New York—1931

Rate Per 100,000

	New York City		*Rest of State*	
	Male	*Female*	*Male*	*Female*
All ages	19.2	13.4	18.2	11.6
Under 5 years	15.2	15.1	7.1	8.2
5-14 years	16.1	12.1	14.3	9.1
15-24 years	12.7	8.5	16.3	8.2
25-34 years	14.2	10.4	16.7	9.9
35-44 years	22.8	12.1	20.8	7.2
45-54 years	25.1	14.8	25.0	17.8
55-64 years	29.6	26.2	25.3	21.0
65-74 years	47.7	34.5	23.9	18.0
75 and over	34.6	25.3	20.5	25.5

The table following will show the deaths and death rates from appendicitis in 1931 and 1932 for the five largest American cities.

Appendicitis Mortality in Five Large Cities—1931-1932

Rate Per 100,000

	1931		1932	
	Deaths	*Rate*	*Deaths*	*Rate*
Chicago	612	17.7	511	14.5
Detroit	291	17.8	241	14.2
Los Angeles	193	14.6	168	12.2
New York	1,157	16.3	1,065	14.8
Philadelphia	274	13.9	223	11.3

(Continued on Next Page)



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(Continued from Preceding Page)

It is shown for the five largest cities that the results conform to the general experience of a decline in the rate for 1932 compared with 1931. Whether this decrease reflects increased surgical skill or an actual diminution in the incidence of appendicitis can not be answered. An answer to this question would certainly be an interesting contribution to medical statistics.

Medical practice in the treatment of appendicitis continues to vary widely as to the best method of procedure. Sir James Berry of London in 1932 raised a country-wide discussion in the United Kingdom by an address on "Fallen Idols" from which I take the following extracts:

"A good deal might be said about the idol of surgical statistics and the illogical and careless way in which such statistics were used. It would be a good plan to have a law which compelled surgeons to submit all surgical statistics to a professional statistician for his comments and advice before publication was permitted."

TABLE 2.—*Appendicitis in Seven California Cities*

	1931			1932		
	Population	Deaths	Death Rate per 100,000	Population	Deaths	Death Rate per 100,000
Fresno	53,413	2	3.7	54,133	0	
Long Beach	152,487	18	11.8	160,851	11	6.8—
Los Angeles	1,318,058	193	14.6	1,382,066	168	12.2—
Pasadena	79,806	5	6.3	82,782	3	3.6—
Sacramento	97,125	30	30.9	99,825	11	11.0—
San Francisco	649,844	101	15.5	662,204	83	12.5—
San Jose	59,825	4	6.7	61,566	4	6.5—

"The modern view was that acute appendicitis was a terribly fatal disease, and must be treated by immediate operation whenever possible."

"It was incorrect treatment, active, injudicious treatment, whether medical or surgical—for the one might be as bad as the other—which did so much harm in acute appendicitis. There was more danger

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in opening an appendix abscess prematurely in the wrong way than in leaving it to burst spontaneously, though this, he need hardly say, was not to be desired. In the old days, with the 'you-must-do-something' school, he was quite sure the bad results were to be attributed to (1) feeding the patient when he should have been starved; (2) giving purgatives and enemas to get the bowels open when it was of importance that they should be kept at absolute rest so long as there was risk of abscess forming; and (3) attempts by drugs or otherwise to relieve the abdominal distension, which was really protective and curative, not harmful in itself. He himself, as far back as 1899, had tried to stem the rising tide of reckless operating, and much was done in the same direction by Treves, whose Cavendish Lecture in 1902 was a classic that should be read by everyone."

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Following this address many interesting letters appeared in the *British Medical Journal* revealing wide differences of opinion as to the best course to pursue. It was my privilege to discuss the situation with Sir James Berry last year during a visit to his home and I became deeply impressed with his views, reaching the conclusion that in many cases medical treatment would have been preferable to an operation. The last word has not been said on this question which involves extraordinary consequences in view of the increasing number of people who apparently are needlessly exposed to the risk of death as the result of uncalled for operative interference. Sir James Berry stands out as one of the few practicing surgeons who philosophically views the situation in the light of a large experience amplified by much disinterested study.

Sir James Berry recalled to me an address of his on "Peritonitis and Its Treatment" contributed to the British Medical Association in 1907. In this address he laid down the principle that

"Our natural surgical tendency in such cases is to remove the septic focus as soon as possible, and a great many surgeons, I think the majority of the surgeons who write upon appendicitis, teach that this should be done. In some cases it is undoubtedly good treatment to do so. But in many cases I venture to

(Continued on Next Page)





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(Continued from Preceding Page)

think that immediate operation is very bad treatment and does immense harm. When we are brought face to face with one of these cases we ought, I think, to ask ourselves first of all what is likely to be the course of events if we do not operate at once? Secondly, what good and what harm may we do by operating at once? Thirdly, if we do operate, what manner of operation should we do, for there are several?"

And further that

"It is exceedingly hard in a given case to give an accurate prognosis. The duration of the illness, the stage which it has reached, the severity of symptoms, and especially the increasing severity of symptoms are the points upon which we must endeavor to base our prognosis and consequently our treatment. But the great majority will improve and pass into a more favorable condition for subsequent operation if not interfered with by operation at this acute stage. If it is decided to abstain from operation at this stage it is extremely important that other treatment should be carried out rigidly. The most important point is not to give purgatives or large enemata and not to give food by the mouth. The patient can do very well without any food for a day or two, and if it be necessary to give him nourishment this can be administered quite well by means of small nutrient enemata. If the patient is thirsty he should be given fluid and the most convenient way of doing this is to inject considerable quantities very slowly by the rectum. Care should be taken not to distend the rectum, but to let the fluid run in so slowly that it is absorbed as fast, or nearly as fast, as it enters. If the patient is not thirsty there is no need to give much water. He should be kept as quiet as possible and should be placed in such a position that the thorax is considerably higher than the pelvis. Any fluid within the abdomen will then tend to gravitate toward the iliac fossa or the pelvis, situations in which it can subsequently be most easily dealt with."

And finally,

"For some years I have treated cases of acute appendicitis of this class and the next on these lines. The number of cases I have had to deal with is no doubt smaller than the number that come to surgeons who have written much on appendicitis. I suppose, too, that I must have been singularly favored by good fortune, for in the last two years I have lost but a single case of acute appendicitis, either in hospital or private practice—a boy who came into the hospital on the second day of a very acute attack. He was not operated upon and he died two days later. A necropsy showed a considerable abscess which had burst, evidently before admission to the hospital, and which had set up a general peritonitis."

I have thought it worth while to quote these observations at some length in view of their direct bearing upon the appendicitis death rate. It is certainly appalling to note the number of deaths which at the present time occur in surgical practice when a different method of treatment might possibly save a valuable human life. The danger is enormously increased when the operation is performed by a junior surgeon without much experience. Unquestionably great surgeons have a brilliant record for successful operations with a very small mortality, possibly not more than two per cent. About thirty years ago I discussed this question with Dr. Frederic S. Dennis of New York City, now retired, and the author of a monumental treatise on surgery, who gave me my first introduction to the problem which has continued to hold my attention from year to year. Doctor Dennis in 1904 published an address on "The Mortality of Appendicitis" in *The Medical News* of January 9 of that year, which unfortunately cannot be reduced to a brief generalization, but it will be found worth studying even at the present time. Doctor Dennis laid down the principle that "Modern surgery has almost completely gained the mastery over the disease. since a mortality of about two per cent can hardly be expected to be

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improved upon in the future." That is probably true but in the meantime the practice of operation for appendicitis has increased enormously and regrettably operations are often performed on the part of incompetent surgeons who help to raise the mortality from year to year.

Doctor Dennis' views show a remarkable conformity to those of Sir James Berry, summarized in the statement that "The mortality of the simple operation is appalling in the hands of an inexperienced surgeon." He recalled the experience of one surgeon who operated upon nineteen consecutive cases with nineteen deaths.

The question of correct procedure in appendicitis often involves extremely difficult decisions. It goes without saying that surgery is preferable but highly skilled surgery is still rare and in country districts often unavailable. My own purpose in calling attention to the problem is merely to emphasize its serious importance and the necessity of further research in the direction of nonsurgical treatment where it may be called for. The death rate for this country is certainly highly disconcerting regardless of the slight improvement during the last two years.

It is shown that the average appendicitis death rate in these fourteen Canadian cities has increased from 15.1 per 100,000 in 1931 to 15.6 in 1932. The high rate for Quebec is astonishing but apparently correct, the data being derived entirely from official sources. The appendicitis situation in both American and Canadian cities is sufficiently serious to demand more extended inquiry and study. The slight decline in 1932 is gratifying, but whether this decline will continue is a matter of pure conjecture.

It is to be hoped that the foregoing statistics will arouse attention and induce local studies of the mortality from appendicitis in localities in which the death rate is apparently decidedly excessive or above the average. Such studies would throw much light upon the question.—From *The Spectator.*



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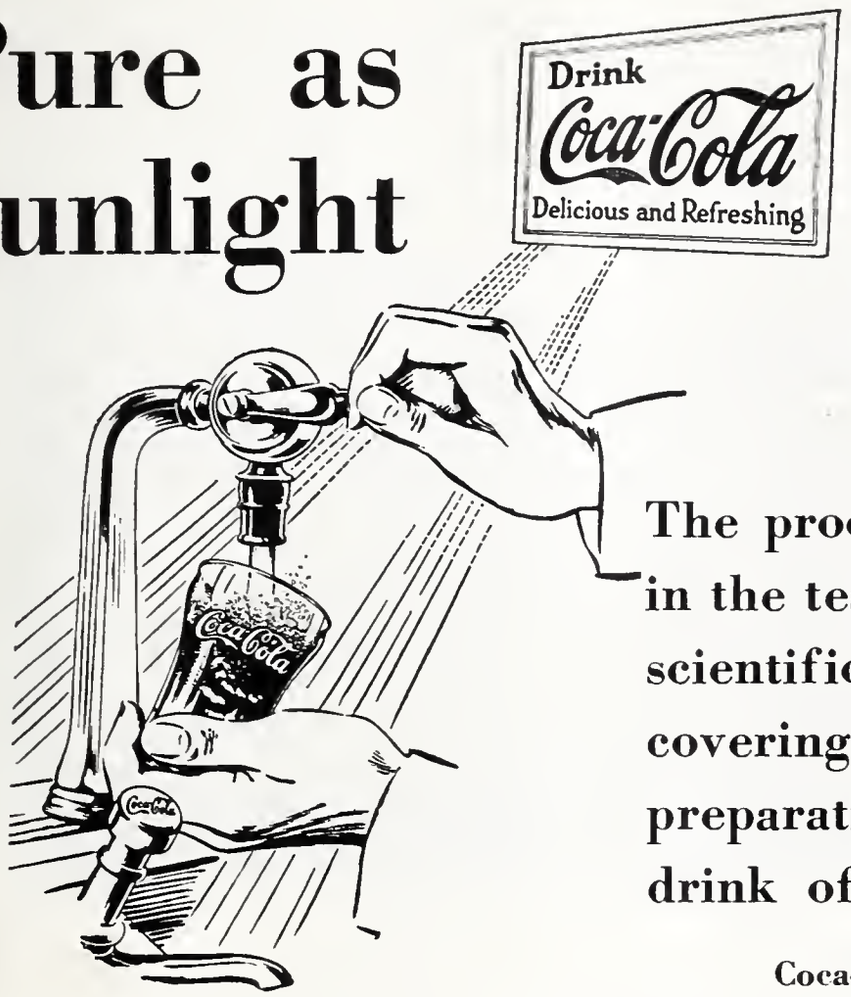
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The appendix contains much valuable data, such as allergy questionnaires, which should help the uninitiated in obtaining a worthwhile history from the allergic patient; also the technique of keeping food diaries and lists of elimination diets with recipes.

Doctor Vaughan's book is probably the most complete and authoritative of the simpler works on the subject of clinical allergy. S. H. H.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 408)

From an article on "A Case of Leprosy in San Francisco Previously Undiscovered" by William Fitch Cheney, M.D., San Francisco.

A boy came to the medical clinic of Cooper Medical College, January 29, 1910, complaining of swelling in his face, hands and feet, and of sores on his legs. The condition resembled one of myxedema, and he was sent into the ward of Lane Hospital with that as the probable diagnosis. . . .

From an article on "Prosecution of Illegal Practitioners" by J. A. Crawshaw, M. D., Hanford.

. . . The object I have in mind is to present before this body of intelligent men a number of facts that I have been able to gather from various sources which I am sure should arouse us from our slumbers, and cause us as representatives of a noble and glorious profession to become more active in protecting our profession and fellow man from the onslaught of the illegal practitioner who uses us and our achievements to carry on his graft to fatten his purse and submerge the medical profession in ridicule by exploiting his newly discovered process of healing or the inheritance of seven generations. . . .

From an article on "A Case of Tumor of the Medulla Oblongata" by L. Newmark, M. D., and Milton B. Lennon, M. D., San Francisco.

In August, 1906, Dr. W. F. Cheney first gave one of us an opportunity to examine the patient, a boy sixteen years old. At that time the boy declared that he had no pain at all, and indeed he appeared quite at ease and was even inclined to be merry. He staggered when walking, had a cerebellar gait, lurched frequently to the right, and there was a decided ataxic fling of the right foot. But of these disturbances, when they were adverted to, he professed to be unconscious. . . .

From an article on "Traumatic Injuries of the Head" by O. D. Hamlin, M. D., Oakland.

In the study of traumatic injuries of the head, the question of diagnosis or the extent of injury is the

(Continued on Page 18)

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BY FLORENCE FISHER PARRY

NOTHING can take his place—not priest nor minister nor all the clinics that science can provide. There is a rapport and a confidence between him and his patient which has been known to accomplish Miracles, and restore to the breasts of mothers babies about to die, and to the arms of lovers, beloved turned back from Death. For there's something about the very presence of the Family Doctor that casts out fear, melts apprehension, breaks down suspense, performs the simple miracle of Faith. We know how hard the life is that he's chosen. We know that he's abused, imposed upon, worn; that his days are not his own, and his nights are snatched and torn. And, we wonder, where are his rewards? What compensation is his? Oh, I think he is greatly repaid; greatly to be envied. His rewards are kingly prizes. The prize of WELCOME. That's a great reward. To have one's presence a blessing. To know that the mere SIGHT of you brings heart's ease; stirs the wan pulse, brightens the fading eye. The prize of CONQUEST. All men like that. Winning against odds. To stay a fever; energize a pulse; throw

breastworks against the advance of disease. Here, indeed, are paths of Glory that do not lead to the grave but AWAY from it. I cannot think of greater conquest. The prize of CONFIDENCE. That's a proud possession. Some priests know it; some ministers; and Friends, if they're time tried. But the Family Doctor is the final confessional, a refuge not only for repentant hearts, but sick and craven hearts as well. The prize of HUMAN WISDOM—that deep knowledge that comes from being continually exposed to the pitiful frailties of mankind. You do not deceive the Family Doctor; you do not attempt to. But knowing you, he is still compassionate; for he has learned to expect little of greatness in his fellow-man. Above all, I think I envy him his prize of SELFLESSNESS. He is FREE, for he has already given up his life, so has nothing left to fetter him. There is much talk of state control of medicine; and legislation dips its partial fingers into the sterile waters of our doctors, seeking to arbitrate over their mission of mercy. I Dare Say there are certain restricted fields of medicine in whose confines the legislative hand could work productively. But the ineffable value of the HUMAN TOUCH in medicine, is something that transcends all legislation. What legislation indeed, what politics, what state control or organized social program, can hope to substitute that HUMAN BOND that exists between the FAMILY DOCTOR and his patient?

FROM FLORENCE FISHER PARRY'S COLUMN "I DARE SAY," WRITTEN AFTER SEEING PETROLAGAR'S EXHIBIT, "THE DOCTOR," AND REPRODUCED BY COURTESY OF THE PITTSBURGH PRESS.

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It is our purpose to publish in this journal every month the facts about some phase of canned food knowledge. We would like to summarize for your convenience the conclusions which authorities in nutritional research have reached.

And here we ask your help. On this page are listed a few suggested subjects. Will you check the ones that you would be interested to read, and write in others that may occur to you? Then simply cut out the bottom part of the page and mail it to us.

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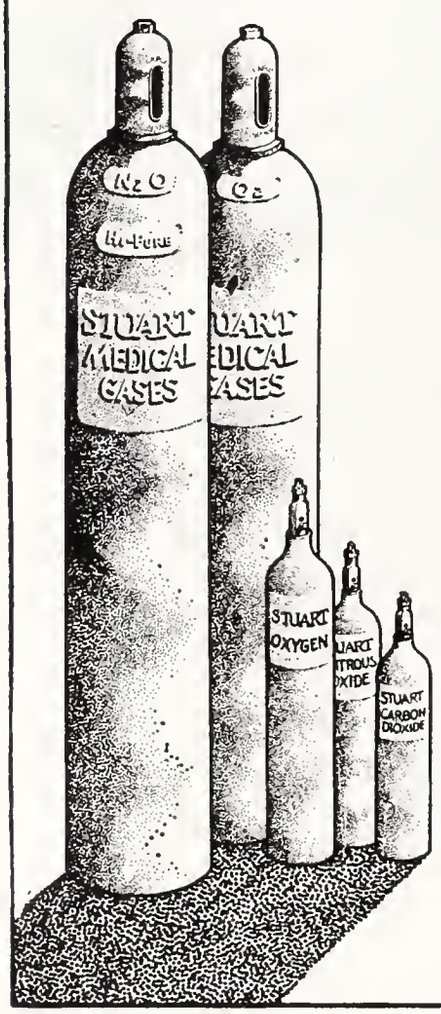
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TWENTY-FIVE YEARS AGO

(Continued from Page 15)

first question of importance. An early diagnosis will lead to proper treatment, and it is often difficult to make a correct diagnosis of concussion, compression from fracture, compression from hemorrhage, fracture without compression with or without hemorrhage, laceration of brain tissue or subarachnoidal serous exudate, which follows some cases of head injury, or a combination of two or more of these conditions, where the symptoms of one overlap into the other. . . .

From an article on "The Psychoneuroses—A Review of the Present Status of Hysteria and Neurasthenia" by Charles Lewis Allen, M. D., Los Angeles.

While nervosity has undoubtedly increased with the steadily growing intensity of the struggle for existence, the functional neuroses have always existed, at least since man attained any degree of culture. As to their presence in all ages, we have abundant evidence both in sacred and in profane literature. The very name "hysteria" has come down to us from ancient times, and the popular designation for this neurosis in most languages bears witness to the persistence of ancient ideas as to its pathogeny, which it appears almost impossible to shake off, for while no one believes today that hysterical manifestations are due to the wanderings throughout the body of a discontented uterus, the connection of this disease with influences proceeding from the genital organs has been curiously reaffirmed in the "sexual trauma in youth" theory of Freud. . . .

Society Reports, Alameda County.—The meeting of the Alameda Medical Association, for February 15, was called to order at 8:40 p. m., Doctor Dukes in the chair. . . . The following resolution, introduced by Dr. H. N. Rowell, was unanimously adopted and the secretary instructed to transmit a copy to the Board of Supervisors:

"Whereas, By reason of the increasing population of Alameda County the present accommodations for the county poor have become entirely inadequate; and

"Whereas, The Honorable Board of Supervisors of Alameda County, keenly alive to the humane duties devolving upon them, have recognized the absolutely imperative necessity of better facilities for handling the sick and have, by resolution, determined to procure a tract of land and erect hospital buildings of the latest type and design, properly equipped, within the city limits of Oakland; therefore be it

"Resolved, That the Alameda County Medical Association does hereby congratulate the Honorable Board of Supervisors upon its recent decision, and offers its assistance in any manner, to the end that our new infirmary be such that it shall reflect credit upon this county generally and afford relief for the increasing number of indigent sick."



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(Continued from Text Page 408)

ployees earning salaries up to $3,000 a year . . . estimated at 2,000,000 persons. . . . Free choice of physicians and complete hospitalization, with time limitations, would be provided for all persons insured. . . . Accident cases also would be covered. Senator Dan E. Williams stated that while approximately $100,000 was spent on the committee's investigation into the high cost of sickness and the report, no money was spent by the State. Contributions were made by the California Medical Association, the Federal Emergency Relief Administration and the State Emergency Relief Administration. Williams said the committee members gave their time to the investigation and served at their own expense." (Sacramento *Bee,* April 12, 1935.)

"Within a week after he was released from jail under $15,000 bail after being charged with an illegal operation and murder of a sixteen-year-old Santa Ana high school girl, Dr. F. D. Coltrin of Fullerton performed another illegal operation upon Mrs. Mary Alice Marshall, 27, of Anaheim, it being alleged in a new complaint against the physician, who was rearrested last night. . . . In the event of Mrs. Marshall's death, a second murder charge probably will be filed, it was stated today by Deputy District Attorney James L. Davis, who has charge of the prosecution. . . ." (Santa Ana *Register,* March 14, 1935.) (Previous entry, November, 1927; February, April and December, 1928.)

"Named defendants in a $1,000,000 damage suit filed in the Federal Court here yesterday were the State Board of Medical Examiners, its members and agents and scores of physicians and surgeons. The action was filed by the Gravitonic Life Ray Estate, Ltd., on behalf of its founder, Fred W. Reed. . . ." (Previous entry, December, 1928.)

"District Attorney Clair Engle of Tehama County Tuesday announced he would ask dismissal of the case against Dr. C. E. Brown of Paradise and Allen Mills of Megalia, charged with violation of the State Medical Practice Act, after Mrs. Edward Freeland, prosecuting witness and widow of Edward Freeland, alleged victim of an unknown 'cancer cure,' indicated a desire to drop charges. . . . According to the complaint sworn to by J. W. Davidson, special agent for the Board of Medical Examiners, Mills collected $100 from Mrs. Freeland and had Doctor Brown wire to Detroit, Michigan, for the 'cancer cure,' which arrived January 7 by air mail, with a C. O. D. charge of $100." (Orland *Unit,* March 14, 1935.)

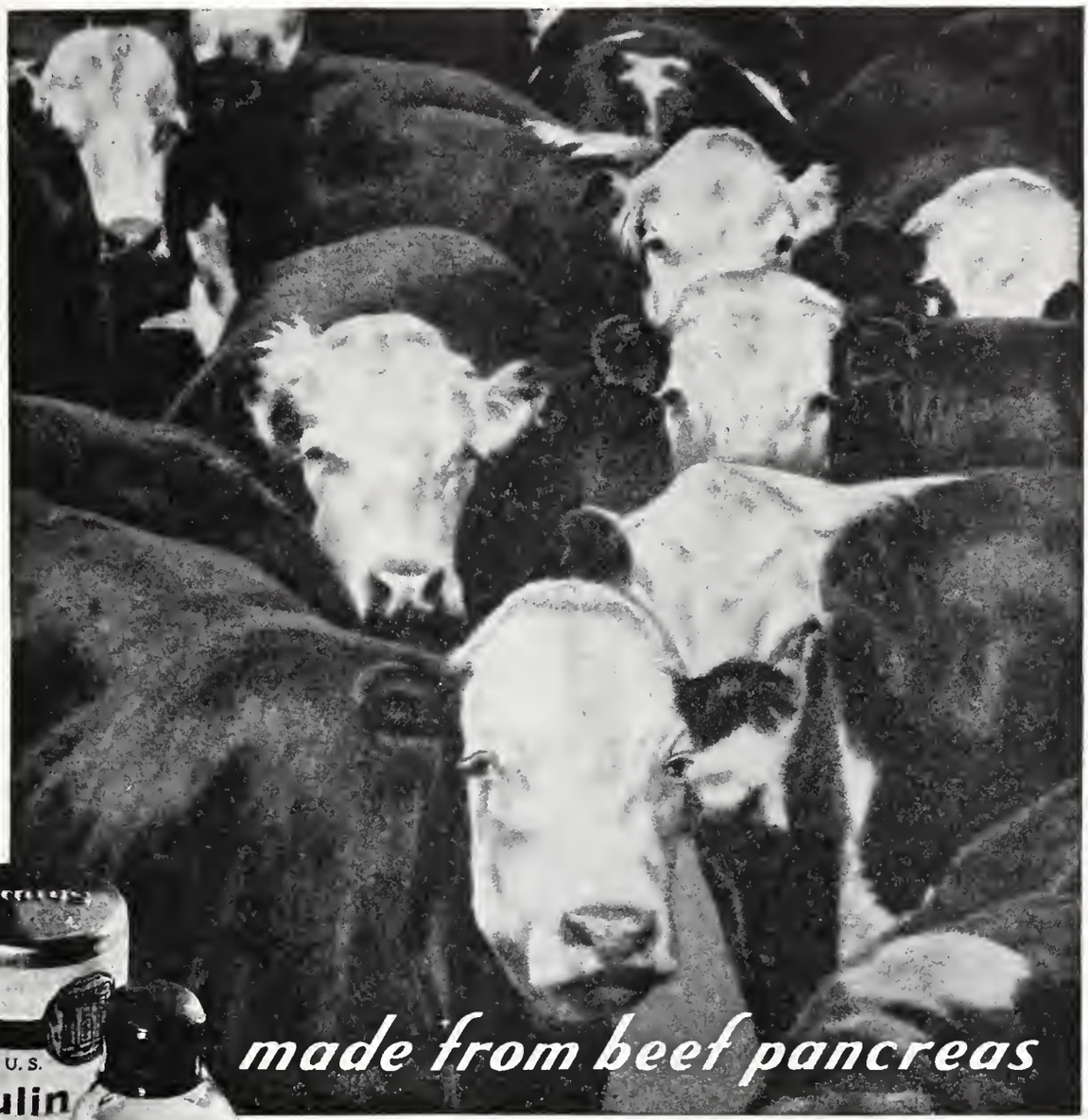
"Seeking to prevent critical illness of persons unfamiliar with the proper use of dinitrophenol and thyroid, powerful reducing agents, the State Board of Pharmacy has passed restrictions upon the sale of these drugs. Hereafter pharmacists will be prohibited from selling the drugs in any form without a written prescription from a licensed physician. . . ." (Los Angeles *Illustrated Daily News,* March 25, 1935.)

"Seriously ill at his home, Dr. Vergil McCombs, Hollywood physician, yesterday pleaded guilty by proxy in Federal Court to an information charging him with income tax evasion. The physician, who lives at 128 McCadden Place, suffered a broken back in an automobile accident some time ago. Doctor McCombs is scheduled to appear April 22 for sentence before Federal Judge William P. James." (Los Angeles *Illustrated Daily News,* March 13, 1935.)

"Three vanished 'spook doctors' took $3,450 away from middle-aged Mrs. Margaret Carillo of 654 Castella Street as a fee for getting 'invisible spirits' to heal her of stomach disorder, she complained today to Detective Lieutenant Thomas Ryan of the Police

(Continued on Page 22)

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(Continued from Page 20)

Bunco Squad. Mrs. Carillo was the latest in a string of asserted victims of Raul Miranda, tall, handsome Argentinian, and his two assistants, Carlos and Anthony Rivera, sought by police as the departed operators of the 'house of skulls,' 430 North Bunkerhill Avenue, on charges of grand theft that may involve a total of $100,000. On February 20, last(according to Mrs. Carillo, she turned over $1,450 to the trio. On February 27, her stomach pains still tormenting her, she gave them $2,000 so that the 'spirits' might intercede still higher up in the hierarchy of spirits. Her stomach still hurting her, she called again to find the place deserted. Police raided the place last Thursday night, finding seven luminous-eyed skulls and black curtains painted with occult symbols." (Los Angeles *Herald-Express,* March 11, 1935.)

"Passionate adolescent love that blossomed in the dance halls and ended with the tragic death of a young bride had its startling aftermath yesterday when the county grand jury . . . returned indictments charging the dead woman's husband and three prominent San Bernardino residents with her murder. The bride of but a few days, Mrs. Margaret Lee Warren, lies in a lonely crypt many hundreds of miles from here in a Hillsborough, Oregon, mausoleum. In the county jail, charged with conspiracy in performing the illegal operation which resulted in the death of the young bride, are her 21-year-old husband, Tommy V. Warren; Scott H. Sinclair, 40, chiropractor; Dr. Clyde A. Pierson, 53, and a nurse, Mrs. L. E. Durbin. . . ." (San Bernardino *Daily Orange Belt News,* March 13, 1935.)

"Fred McKee, 55-year-old Long Beach 'tattoo artist,' and his wife, Edith McKee, 25, today faced the prospect of being among the first to go before the

Mrs. Iola Barnebee Pierce

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1935 county grand jury after their arrest yesterday upon the complaint of Dr. Samuel Young of Long Beach, who charged they had blackmailed him out of $1,000 and made demands for a second thousand. According to Blaney Matthews of the district attorney's office, Doctor Young said Mr. McKee had beaten him last February 20 when the doctor allegedly paid the man $1,000, after being accused of undue friendliness with Mrs. McKee. The McKees were questioned at the district attorney's office and were held pending possible action by the new county grand jury." (Los Angeles *Evening Post-Record,* March 15, 1935.)

"L. P. Lorrainee, 42-year-old male nurse, last night was acquitted by a Superior Court jury, after less than an hour's deliberation, on a charge of performing an illegal abortion on Dorothy Smalley, 20-year-old Teyserville taxi dancer. . . . (Sacramento *Bee,* March 9, 1935.)

"Municipal Judge Alden Ames looked at the mark on Mrs. Ray Bond's head, then he looked at the trousers Dr. Harry Bond, her chiropractic husband, was wearing. 'It doesn't seem possible,' said the judge. 'But there was $20 in silver in one of his pockets,' Mrs. Bond explained. Doctor Bond was charged with striking his wife during an altercation at their home, 1785 Lombard Street, and was given a six months' suspended sentence." (San Francisco *Examiner,* April 10, 1935.) "Dr. Harry Bond was fined $25 by Municipal Judge Alden Ames yesterday on a charge of malicious mischief. . . . Previously Doctor Bond was given a suspended sentence for hitting his wife with a pair of pants. . . . The charge grew out of the hurling of a statue and several flower pots through the front door at 1785 Lombard Street. . . ." (Press dispatch dated San Francisco, April 13, printed Oakland *Tribune,* April 13, 1935.)

(Continued on Next Page)

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(Continued from Preceding Page)

"Dr. Charles H. Ames, local chiropractor, was given a complicated sentence this morning when he appeared before Judge Starkey for a probation hearing on charges of violation of Section 17 of the State Medical Act. The sentence included a fine of $300 or 150 days in jail and sixty days in jail and two years' probation. Judge Starkey then suspended $175 of the fine and the jail sentence, on condition that Doctor Ames report each month for two years to the state probation officer and does not violate any part of the State Medical Act. Doctor Ames was ordered to pay the $100 fine this afternoon. He was found guilty at a jury trial several weeks ago after state medical authorities had charged that Doctor Ames had violated the Act by treating the sick or practicing with the use of medicine, without a certificate to do so." (Whittier *News,* April 26, 1935.)

"Unable to reach a verdict after five and one-half hours of deliberation, a jury trying Dr. Walter Pike, Oakland physician, on charges of illegal sale of morphin, was discharged by Superior Judge Fred V. Wood last night. The jurors stood eight to four for conviction. Doctor Pike was charged with having sold morphin to an operative of the State Narcotic Division without a prescription. The defense vigorously attacked the truthfulness of the operative, chief prosecution witness. Date for a second trial of Doctor Pike will be set on Monday." (San Francisco *Examiner,* April 5, 1935.)

"A tragic result of 'bargain' buying in local cut-rate drug stores was evidenced recently when the Santa Monica Hospital reported the death of two emergency cases, resulting from poorly prepared prescriptions, filled by this chain outfit. At a physicians' meeting this week, prominent medicos of the Bay District expressed a warning to all residents who might need the aid of a pharmacist, to the effect that prescriptions should be filled at a reputable, ethical pharmacy. . . ." (Reprint from Santa Monica *Independent,* printed in Glendale *Times,* March 29, 1935.)

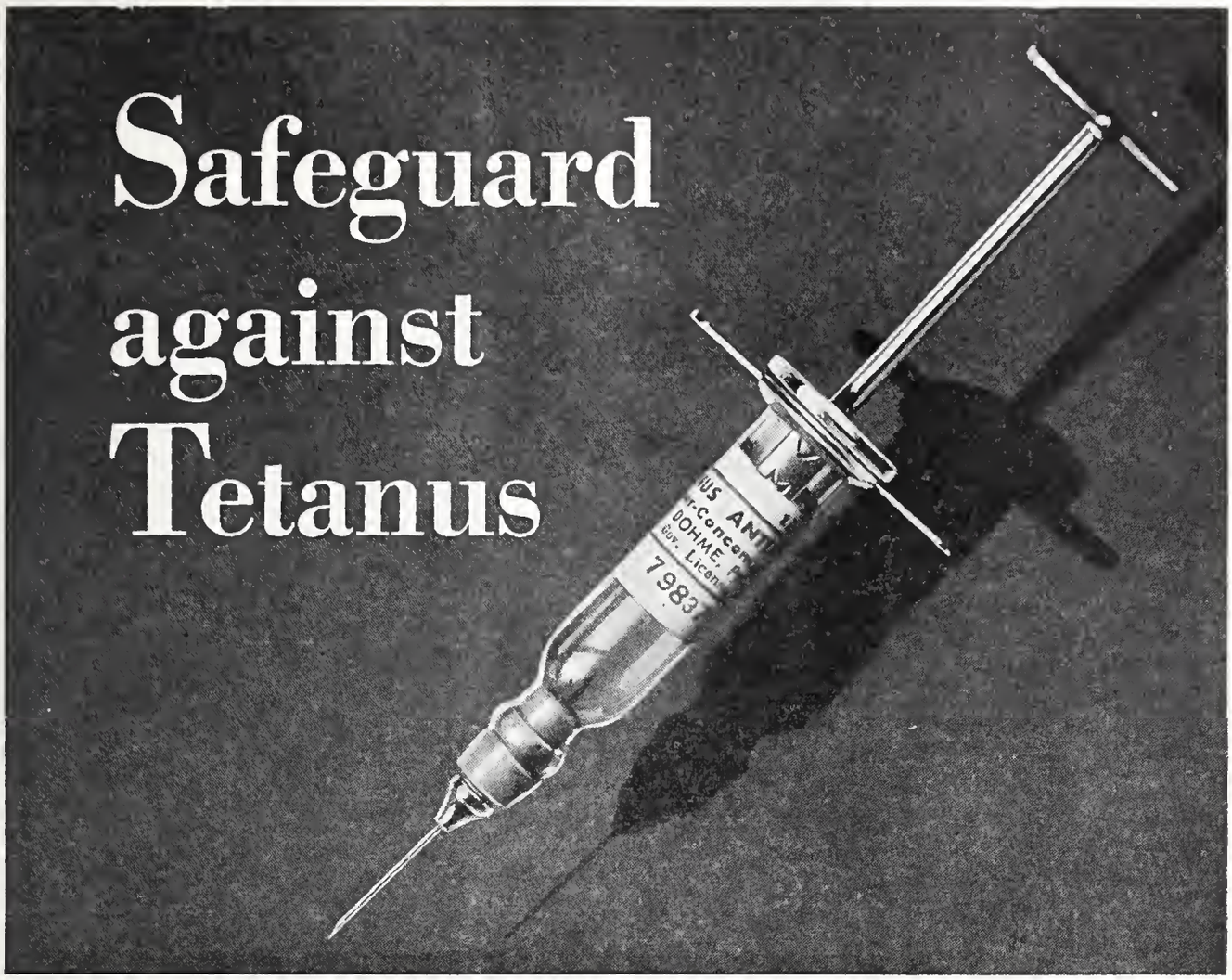
Among the list of ten reported in the Sacramento *Bee* of April 16, 1935, as indicted by the Federal Grand Jury, appear the following: "Dr. R. B. Smith of Alturas—illegally sending morphin through the mails to John Brisco of Seattle."

"Charged with conspiracy to violate the California Medical Practice Act by operation of a cancer clinic at 1411 High Street, William F. Hoque and his son, Herbert V. Hoque, had today pleaded guilty before Superior Judge Fred V. Wood. They will appear for sentence Thursday. Both Hoque and his son were arrested January 19 and were scheduled to go to trial yesterday. At the last moment they changed their plea to guilty. Neither Hoque nor his son is a licensed physician, George Perkins, assistant district attorney, informed the court." (Oakland *Post-Enquirer,* April 9, 1935.)

"Dr. F. M. Bantum of 102 West Vernon Avenue entered a plea of guilty to a charge of violating the Harrison Narcotic Act before United States District Judge Hollzer yesterday. April 22 was set for sentence. He was accused of illegal issuance of prescriptions." (Los Angeles *Times,* April 10, 1935.)

Reports from New Jersey indicate that Samuel R. Lustberg, M. D., was, on or about March 18, 1932, sentenced to the New Jersey State Prison at hard labor for a term of three years and to pay a $1,000 fine and to stand committed until said fine be paid, he

(Continued on Page 26)



IN the emergency treatment of contused, lacerated and penetrating injuries, authorities agree on the immediate administration of 1,500 units of tetanus antitoxin as a safeguard against tetanus.

Because of its small volume and low protein content, Tetanus Antitoxin Super-Concentrated Mulford is well suited for this purpose. It is easily injected, is rapidly absorbed and produces almost immediate protection. The small volume and low protein content also reduce the incidence of local and systemic reactions.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

assertedly having been convicted with others in an alleged conspiracy to defraud insurance companies by means of fake entries arising from alleged automobile accidents.

Licentiates are warned against a young man, now reported traveling through the state, who requests a physical examination because of his pending marriage, at the conclusion of which he tenders his check in excess of the fee, collects the balance and departs. The check is returned marked "Not Sufficient Funds."

On March 19, 1935, the District Court of Appeal of the Second Appellate District sustained the Board of Medical Examiners in its revocation, on October 18, 1932, of the license of Dr. Eugene J. Rinaldo (80 C. A. D., P. 1154).

An alleged imposter calling himself Dr. L. E. Du-Bois and, according to reports, claiming connection with the Board of Medical Examiners, is said by prominent hotels in Fresno, Sacramento and San Francisco to be obtaining money by checks which later are returned marked "Not Sufficient Funds." His description tallies with that of Frank J. C. Miller, Los Angeles Police Department No. 30693-M-11.

If education does not afford opportunity for wholesome recreation and trained capacity for seeking and finding it, the suppressed instincts find all sorts of illicit outlets. . . . Education has no more serious responsibility than making adequate provision for enjoyment of recreative leisure; not only for the sake of immediate health, but still more if possible for the sake of its lasting effect upon habits of mind.—John Dewey **(1915).**

California Vital Statistics for Year 1934:

Nineteen Thirty-Four Death Rate Is Lower.—The general death rate for California last year was 11.1 per 1,000 population as compared with a rate of 11.2 per 1,000 population in 1933. There were 68,091 deaths registered in 1934 as compared with 67,992 registered during the preceding year. There were 15,008 deaths in the city of Los Angeles, which represents 22 per cent of the total. The general death rate for that city was 10.9 per 1,000 population. In San Francisco there were 7,995 registered deaths, which gives a general death rate of 12.1 per 1,000 population.

It is unfortunate that facilities are not available for making adjusted death rates. The crude rates make distorted pictures of true conditions in the various cities and counties. For example, the city of Los Angeles is credited with deaths of county residents outside of the city who die in the Los Angeles General Hospital. Cities and counties within which large State institutions are established, such as Stockton, Napa County, Santa Clara County, and San Bernardino County, suffer unfavorable records because of the high death rate that prevails in institutions for individuals who suffer from mental and other illness. Counties within which large numbers of institutions for the treatment of tuberculosis are located also suffer high death rates because of the fact that such institutions attract many advanced cases of the disease. This would apply to Placer, Santa Clara and other counties, as well as certain cities. Death rates for some of the mountain counties are high for the reason that many of the younger residents of the county have moved away, leaving only an old adult population within the county. This would apply particularly to Calaveras, El Dorado, Mariposa, Mono, Plumas, Trinity, and Tuolumne counties.

Birth Registration. — The birth-registration project which was started in January of the present year,

(Continued on Page 28)

A System for the

Collection of Fees

that has proved its worth

Our bookkeeper fails to find your account settled on our books. Please help him out.



PAST DUE!

This Account has no doubt escaped your notice. Will you please favor us with a remittance by return mail and oblige?

THIS ACCOUNT
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PLEASE REMIT.

Regarding Your Past-Due Account

Our records show that several statements and reminders have been sent you regarding the enclosed statement.

If your circumstances have made it impossible for you to pay the amount due, kindly write us promptly to that effect. Our office will then endeavor to extend all possible courtesies.

You appreciate, we are sure, that physicians, like other citizens, must pay their bills promptly. They can only do so, however, when their own clients in turn pay them promptly for such professional services as may have been rendered.

A check to cover your account, which is now considerably overdue, will be appreciated.

Final Notice

In practically all businesses the custom which is generally followed with overdue accounts is to send such to a collecting agency.

Our bookkeeper has nothing in the records of the office to show when you intend to pay the enclosed account. Perhaps the previous statements and reminders may have been overlooked or ignored.

Following the rule of this office, this overdue account will be sent to the collecting agency within ten days if arrangements for its settlement are not made prior to that time.

This collection bureau method is disagreeable to us; and we believe, also to you. By promptly sending your check all this can be avoided.

When an account is sent to the collecting agency that organization takes full charge of it thereafter.

In the September, 1927, issue of California and Western Medicine, page 398, appeared an article relating to the "collection of fees." Following this publication so many orders were received by us for printing the series of gum stickers and notices, we decided to print and stock the series in large quantities.

That we were justified in this decision is evidenced by the fact that thousands of these notices have been used by the medical profession of California. They *get* results. Many users of the system have reordered the series.

You, too, can profit by using the system for your delinquent accounts. They are inexpensive and easy to use.

The prices, including postage, are:

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Laryngoscope, 1935, XLV, 149-154★

SEE ALSO

Pharmacology of Inflammation: III. Influence of hygroscopic agents on irritation from cigarette smoke.
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

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KIP* GENTIAN *(Spray)*

Represents the lenitive oils of Anti-Pyrexol and Gentian Violet in solution. Recommended as a spray for extensive burns where open treatment is indicated. Forms light, tough, elastic, eschar that inhibits germ growth. Anodyne, non-toxic; bactericidal and bacteriostatic in vivo; mildly analgesic and aromatic. Possesses properties of great penetration. Suggested, too, in the treatment of cuts, scratches, tinea circinata, epidermophytosis; as an oral swab in the treatment of Vincent's angina, and affections in which staphylococci and B. diphtheriae are the causative agents. Packed in 1 oz. (with glass applicator), 4 oz. (with spray and glass applicator), pint, quart, and gallon bottles.

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** Reg. U. S. Pat. Off.*

(Continued from Page 26)

terminated at the end of March and was immediately renewed so as to extend over another ten-week period. Up to the end of March, 35,126 names of infants born in 1934 were submitted by parents through the United States Bureau of the Census for checking with the records on file in this office. Of this number, 2,755 were not found registered. This represents a deficiency of more than 7 per cent. Because of the fact that many names are misspelled and are submitted incorrectly, original certificates cannot be found for the reason that names do not agree. By sending out circular letters and securing additional information from them, more certificates are being found continually and it is believed that when the campaign ends, it will be found that birth registration in California is between 95 and 97 per cent perfect.

Mr. Walter B. Carter, Special Agent of the Bureau of the Census, left for Washington at the end of March and the campaign is now under the direction of the Chief of the Division of Vital Statistics, who has one supervisor and fifteen clerks, each of whom is employed for thirty hours each week. Before his departure, Mr. Carter made preparation for circularizing the clergy of California, both Catholic and Protestant, requesting them to submit lists of names of children who may have been born within their respective parishes during the year 1934. Mr. Carter secured the full endorsement of Archbishop Mitty in San Francisco and Archbishop Cantwell in Los Angeles before launching this activity. The lists from the clergy are now coming into the office in large numbers. It is believed that this line of work will stimulate birth registration among the Mexicans of Southern California, the only place in the State where birth registration is conspicuously deficient.

Employment of Commercial Artists. — The group of twenty-five commercial artists, employed under the supervision of the Division of Vital Statistics through SERA funds, have been employed continuously during



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March in making maps of California counties, outlining local vital statistics registration districts, in making graphs and posters to depict the growth and development of nursing education, posters pertaining to the eradication of ground squirrels and rats, plague pathology in rodents, and related subjects. In addition, a large number of charts pertaining to mortality, oil paintings of pioneer public health men in California, and other material have been prepared.

Accidental Deaths in 1934.—There were 5,566 deaths from accidental causes in California last year. Of these, 2,798 were due to motor vehicles, 1,292 were due to accidents in the home, 1,025 were in public accidents not involving motor vehicles, and 414 were occupational. There were 333 deaths from drowning, 53 deaths in air transportation, and 56 in water transportation. There were but twenty-two deaths in the State due to conflagration, burns, and explosions.

Motor-vehicle deaths in 1934 are classified as follows:

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There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

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MANGANESE	1.3 parts per million
IRON	12.5 parts per million
CALCIUM	173.3 parts per million
MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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MOTOR-VEHICLE DEATHS IN 1934

	All Ages	0-4	5-14	15-24	25-64	65 and Over
Total	2,798	52	147	480	1,667	452
Collision with pedestrian	959	29	71	48	516	295
Collision with other motor vehicles	849	6	23	197	542	81
Collision with railroad train	104	1	2	17	77	7
Collision with electric car	64	1	..	11	45	7
Collision with bicycle	50	1	23	9	11	6
Collision with horse-drawn vehicles	2	..	1	..		1
Collision with fixed object	166	1	6	49	105	5
Non-collision	604	13	21	149	371	50

(Continued on Page 37)

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CALIFORNIA STATE BOARD OF HEALTH*

WITH COMMENTS ON ITS ACTIVITIES DURING THE LAST TWO YEARS

By HOWARD MORROW, M.D.
San Francisco

FROM time immemorial the prevailing political framework and philosophy of the particular period have controlled the public health activities. While the preventive practices of the Egyptians were guided by superstition and magic, those outlined by Hippocrates were dissociated from religion, and were rational. Application of the scientific method, reliance on the inherent physiological faculties of the body to predispose to disease and to resist it, inductive logic and an understanding of social and moral values were the beginnings of modern preventive medicine. Public medical service and sanitation, as practiced by the medical officers of ancient Rome, reflect in every respect the modern concept of public health—the protection of the people against environmental influences which may exercise a detrimental effect upon their physical or mental being. These officers of health were not only engaged in military service, in sanitation and in epidemiological duties, but were responsible for the planning of towns, the building of houses and the treatment of the poor.

THE EVOLUTION OF MODERN PUBLIC HEALTH

Modern public health, evolved through a great deal of organization, is certainly not the product of present-day science, irrespective of the fact that its greatest triumph during the past hundred years is based on the science of sanitation. Public health is more than sewage disposal, water purification, food inspection, and quarantine. These functions, assumed today by certain organizations, are merely a *means to an end;* in fact, *it is only the end that is public health itself.* Thus, public health remains a strictly social and essentially philanthropic field, which is imposed upon every medical and dental practitioner, as vaguely defined as the ethics by which he guides his professional conduct. If medicine is to progress, it must carry out its work of public health; and since ultimately the physician remains the social arbitrator between men and their environment, it is impossible to separate preventive from curative medicine, or preventive from restorative dentistry. Provided some of the insidious attempts at a separation of preventive from curative medicine are not stopped, the time may arrive at which the health department is reduced to that of sanitary police, while the health-promoting functions are carried on by the non-medical welfare agencies. The close cooperation of the patient and physician, which is essentially a social aspect of medicine, is just as important as sanitation itself. It is this side which has to be preserved and strengthened. By tradition, medicine is a social calling, not a business, nor even a science.

THE PUBLIC'S VIEWPOINT OF MEDICINE

In the eyes of the public, medicine is synonymous with social duty. The exponent of medicine will only acquire prestige provided he or she is willing to assume the social obligations inherent to the profession. That prestige is indispensable, for the display of the various measures of public health is a recognized fact. It is apparent that the general practitioner, and even the specialist, has failed as a public health worker, largely on account of the decline of his prestige. The socially minded quack may attract more people than the well-trained practitioner. Poor observers have attributed this change to the public. There is no proof that the public has changed, but the highly technically equipped physician has become less and less socially minded and, therefore, less able to carry out the function of public health. On the other hand, there is little convincing evidence that the medical officer in public health, on account of his official status, is in a better position. Ulti-

* From the Office of the President of the California State Board of Health.

mately, the social problems of medicine are solved by intimate social contact between patient and doctor, and not by an abstract official relationship. The strength and success of a health department depend entirely on the social mindedness of its own staff, and also the prestige of the medical practitioners of the community or the state in which the unit operates. A close interrelation between the Public Health Department and the practitioner of medicine must be maintained and continuously encouraged. In this connection, it is obviously imperative that the privileges and prerogatives of the practitioner of medicine must be preserved with respect to the services to be rendered.

THE STATE HEALTH DEPARTMENT AND HEALTH INSURANCE

At a time when the subject of health insurance is before the legislature, and the desire among many physicians and lay organizations to have the poorer classes treated by practitioners of medicine who are to receive their compensation from the State or from corporations, the Department of Public Health is at the crossroads. The pertinent question, Shall all public medical and health work be done by the health department; in particular shall the State Board of Public Health venture into the treatment of disease? may have to be answered in the very near future. It has always been the aim of the Department to restrict its activities to the prevention of disease, to the diagnosis of doubtful or new infections, to the control of epidemics, and to the judicious education of the public. The director is duty bound to consult with the county and city health officer, and to provide such aid and counsel as may be required in the solution of the many diversified problems which constantly arise. Needless to emphasize, the effectiveness of this coöperation is vastly enhanced through the existence of full-time health units, managed by men adequately trained in public health matters. The Board advocates the development of full-time health departments. It is fully cognizant of the fact that one-half of the rural population has no public health service, and, furthermore, that public health has not attracted the best medical graduates, since the financial rewards are modest and openings not influenced by partisan politics are few.

THE BOARD OF HEALTH AND THE NEW SOCIAL ORDER

The growing concern for the unserved or poorly served—a new spirit of evangelism—which permeates the medical profession may in due course influence the policies and functions of the Board. May I assure you that any change of policy will always consider the prerogatives and the privileges of those who will be invited to render the new service! In this connection I also wish to remind you that the Board has assumed its function in an advisory capacity, a council which will bring together expert medical opinion and sound judgment in the administration of public health matters. The members of the Board, as practitioners of medicine, are fully cognizant of the fact that today men and women die prematurely from diseases which are controllable or preventable by methods already available. These methods are neither sanitation nor other impersonal methods, but they consist of a close coöperation of patient and physician. It is the belief of the Board that this social aspect can best be administered by the practicing physician under the guidance of a full-time health officer. The director of the department assumes this obligation, and he in turn is aided by the members of the Board who, as physicians, have the social contact and the prestige to interpret the needs of the public.

THE TRADITIONAL FUNCTION OF THE STATE BOARD OF HEALTH

Traditionally, the State health department has assumed the function of an agency to recommend improvements in public health sanitation. More and more this activity has been taken over by the local health departments or the civic organizations of the communities. The Board is, therefore, frequently called upon to decide whether or not the improvements recommended are desirable, practical, and economical. Obviously, it can only act judiciously, provided it has at its disposal sound information and has, through personal or written investigations, established contact with the problems involved.

RELATIONS OF THE STATE BOARD OF HEALTH TO ITS DIRECTOR

The advice which the Board can give its director depends entirely on the accuracy and completeness of the data available. A great deal hinges on the completeness of the data which deal with the registration of disease. It is a well-known fact that test canvasses, through house to house surveys, have shown a striking incompleteness of the morbidity records. In Illinois, for example, it was discovered that only 30 per cent of the poliomyelitis and 66 per cent of the smallpox cases had been reported. We should promote a wider appreciation of the axiom that every case of infectious disease is a public matter, and that the diagnosis of a disease is always a coöperative undertaking, and as such is a very important function of the State Board of Public Health. Through its ramified contacts with the profession, it can, in my judgment, perform this obligation to an admirable degree.

With the legislature reconvening on Monday, March 4, the members of this organization may be interested in a brief outline of the unusual demands made upon the health agencies of this State during the past two years.

Communicable disease control constitutes the foremost obligation of official health agencies. Organized effort on the part of health departments will reduce to the minimum such diseases as diphtheria, plague, rabies, smallpox, and typhoid fever. The health officers and the public health nurses, through their continuous contacts

with families, are able to educate the laity regarding measures which may reduce the seriousness of infections such as diphtheria, poliomyelitis, scarlet fever, measles, mumps, whooping-cough, and tuberculosis. They are in a position to emphasize the benefit to the patient of good medical care early in the course of the disease. The control of most of the communicable diseases rests with the local health departments—the responsibility is theirs, with the State Department in the background ready to lend assistance when needed and to keep them advised regarding the best procedures to follow.

BUBONIC PLAGUE IN CALIFORNIA

There are some exceptions, however. The control of plague in California is the responsibility of the State. In those areas of California where plague is endemic among the ground squirrels, continuous plague eradicative measures are carried on, and there must be no break in this program. During 1934 we were reminded that not only should plague-control operations be carried on in those areas known to be infected, but also that the State Department of Public Health should maintain sufficient personnel to survey other counties so as to determine the extent of plague infection in California.

In the fall of 1933 high mortality was observed among the ground squirrels in the Lynn Valley near Glenville, Kern County. The exact nature of the deaths was not recognized until 1934. During the months of March, April, May and June, thousands of ground squirrels succumbed to plague in an area covering parts of Kern and Tulare counties. This new focus is closely adjacent, and partly involves the Tule Indian Reservation. This plague epizoötic was of such virulence that the squirrel population of that area was soon practically eliminated by the infection itself. Plague infection had not been proved on the east side of the State prior to this, and as far as investigations have been completed the source of this newly infected area has not been determined. Through coöperation with the State Department of Agriculture the United States Biological Survey and the United States Forestry Service, as well as the Agricultural Commissioners, an extensive and effective squirrel eradication program has been executed within and surrounding the infected area. On account of the fact that this area is sparsely populated, and the infection occurred before the vacation season, only one human infection was brought to the attention of the Department. This ten-year-old boy suffered from a bacteriologically proved bubonic plague infection in June. He made a partial recovery, but died in October with signs of marasmus and secondary plague meningitis. This unique observation established for the first time in California the occurrence of chronic plague with all of the possibilities of human to human transmission through human fleas.

At the time this epizoötic among the ground squirrels in Tulare and Kern counties was under investigation another similar epizoötic among squirrels was reported in Modoc County. Even more disconcerting was the discovery that this was rodent plague among the Oregon squirrels and the brush rats in the vicinity of Alturas, Modoc County. The infection was particularly heavy in the Fandango Valley, near the Oregon border. We are at a loss to explain the origin of this focus. In this connection, however, it must be recalled that a fatal human case of bubonic plague was recognized at Lakeview, Oregon, during the month of May—two months before the outbreak at Alturas was established by this department. The State Department of Public Health, in coöperation with the United States Public Health Service, will conduct a thorough investigation of the extent of the infected area. The federal service will extend the investigation into Oregon and Nevada during the coming season, provided federal funds are available. Because of the rapidity with which plague may be transmitted through the squirrel and rat population, and because of the experience in California with both bubonic and pneumonic infections in man, plague eradication is an item requiring recognition in the health department's budget.

STATE BUREAU OF EPIDEMIOLOGY

The State Department of Public Health employs statistical methods for predicting epidemics of those diseases which are not included in the group controlled by man. During February, 1934, an epidemic of poliomyelitis was predicted for the summer. This epidemic was the most extensive ever recorded in California, but the mortality was the lowest. That 3,333 cases were reported may be due to a more complete understanding of the diagnosis of nonparalytic cases. The cases were milder than in some of the previous epidemics. All of the histories have not been tabulated, but we have reason to believe that a lower percentage of those cases having central nervous system involvement will have residual paralysis. It is interesting to note, however, that a higher percentage of the cases developed among persons of the older age groups. In the 1912 epidemic 78 per cent of the 531 cases reported were in children under eight years of age; in the 1930 epidemic 59.4 per cent of the 1,876 cases were in children under ten years, and last year 42.2 per cent of the 3,333 reported cases were under ten. Most unusual of all was the number of cases of poliomyelitis among physicians, nurses, and hospital attendants in those hospitals caring for poliomyelitis patients. This was observed in several counties, but no explanation can be offered at this time. Sixty-nine per cent of the total cases reported occurred in the southern part of the State. In the northern section those counties which, for the most part had relatively few cases in the 1930 epidemic, reported the majority of the cases. Toward the end of the year the disease was particularly prevalent in Kern County, and a small outbreak of high virulence occurred in the vicinity of Sacramento.

Typhoid fever is usually localized so that full-time local health departments are able to determine the source and bring the epidemic under control. However, during the fall of 1933, two hundred and twenty-two cases of typhoid fever were reported from three counties—Santa Barbara, Los Angeles, and San Diego. There were three separate epidemics of typhoid fever which started during the early part of November and terminated six weeks later. Undoubtedly, some food product which was contaminated was distributed to Santa Barbara, San Diego, and certain sections of Los Angeles County. The duration of the infection was definitely limited, and by the time the cases were considered a part of a tri-county epidemic the contributing source had disappeared and could not be located. The occurrence served as a warning, however, as to the possibility of such outbreaks appearing in widely separated areas due to a common food supply. It must be admitted that with the increased diversity in food handling it has become exceedingly difficult to trace with absolute certainty sources of typhoid infection. The lesson which we can draw from this tri-county epidemic stresses again the importance of initiating investigations early in the course of the epidemics. The State Department of Public Health is always prepared to place at the disposal of the physicians and health officers experts who are associated with this department.

BUREAU OF CHILD HYGIENE

The Bureau of Child Hygiene, which includes prenatal care, has been greatly handicapped by lack of funds. For a properly organized bureau, we should have a rural nursing service. This should consist of an adequate staff of nurses and additional supervising physicians. More county hospitals should develop facilities for prenatal care and for baby-health supervision. In view of the fact that one birth in seven occurred in county hospitals, it is quite evident that there is a large field for educational, medical and nursing work. In 1930, 17 per cent of births in California were among Mexicans, while 38 per cent of the infant mortality occurred in that race. This illustrates further the need for more educational work in prenatal, infant and maternal hygiene. The educational work of this bureau also includes imparting to mothers the value of early immunization against diphtheria and smallpox. The success of this phase of preventive medicine depends upon the coöperation between both official and non-official health agencies and the members of the medical profession. Those engaged in health education emphasize to the families the value of immunization, and the health departments should render immunization available for those not given the protection by the family physician.

Unfortunately, one must always be content with what is practicable, remembering that habits remain second nature, and that only a slow process of evolution will ultimately accomplish what is considered best.

384 Post Street.

AMEBIASIS—IMPORTANT ASPECTS OF ITS TREATMENT*

By HAMILTON H. ANDERSON, M. D.
San Francisco

DISCUSSION *by John V. Barrow, M.D., Los Angeles; Herbert Gunn, M.D., San Francisco; William C. Boeck, M.D., Los Angeles.*

IN the treatment of any severe and/or therapy-resisting disease, necessitating the administration of potent and oftentimes toxic drugs, one must be watchful for an extra group of symptoms due, not to the disease, but to the toxic effects of the drug administered. Each time a new drug is introduced clinically there is also introduced the possibility of a new symptom-complex. In amebiasis, emetine, when used in excess or inadvisedly, may cause a condition similar to beri-beri, with special emphasis on the cardiac aspects. With the arsenicals and the halogenated oxyquinolin derivatives, toxic states may develop which further embarrass an already damaged system. Certain other drugs, particularly bismuth subnitrate, may produce untoward blood effects which could be avoided if other salts of bismuth were used. In amebiasis, as in other chronic disease states, it is a matter of selecting the least harmful, most effective therapeutic agent of several now available; and this choice depends chiefly upon good clinical judgment, aided by a knowledge of critical laboratory studies.

BASIS OF THERAPY

Considerable discussion has been devoted to the treatment of amebiasis based on the *in vitro* and *in vivo* effects of various drugs on the pathogenic ameba. Little attention has been paid, however, to the patient's response to the amebic infection, i. e., *the disease hazard;* and even less interest is shown in the systemic effects of the more important drugs now used in controlling the infection, i. e., *the therapeutic hazard.* It is this phase of the problem with which we are concerned in this discussion, i. e., *the response of the ameba-infected individual to present-day therapy.*

AMEBIASIS IN TEMPERATE CLIMATES

Amebiasis in temperate climates usually does not produce such severe symptoms as to require long-continued treatment with large amounts of toxic agents, except in resistant cases. It is more likely to be a state of chronic ill health, easily confused with other gastro-enteric infections, and capable of being diagnosed only when E. histolytica is demonstrated in the freshly-passed stool. Amebiasis affects chiefly the large bowel, although the liver also may be involved often, or perhaps always, to some degree. In the average patient the disease hazard is not great enough to justify an added therapeutic risk. We must weigh, then the amount of damage present, the duration

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of infection, the chance of cure, and the probable sequelae remaining after amebae have been eliminated. Every cyst passer, however, regardless of symptoms, is a public health problem and requires treatment, not only to insure his own future health, but also that of his immediate household and of his community. Moreover, once a diagnosis of amebiasis has been made, every member of the infected individual's household should be examined. Those found to be infected should be treated simultaneously in order to eliminate the chance of reinfection, which is probably more common than relapse.

AMEBIASIS THERAPY NOT SIMPLE

James,[1] commenting on treatment, states that "Those who are familiar with the gross and microscopical pathology of amebic infection do not expect to cure their patients with a few doses of any so-called specific, within a few days, or even weeks. The many systems of treatment employed, the wide divergence of opinion as to their efficacy, the number of drugs that have been proposed from time to time, offer eloquent evidence as to the long duration, frequency of relapse, and stubbornness of the disease. The difficulty of curing peptic and duodenal ulcers, even the smallest ones, by medical treatment, is well known, and good results have been obtained at times by radically different methods. In intestinal amebiasis there may be from two or three to many ulcers of the colon, and sometimes ulcers of the appendix as well, as large or larger than those found in the stomach or duodenum, and equally as chronic. I do not know why the former should be supposed to heal more rapidly than the latter; yet there are those who advocate a few doses of emetin, ipecacuanha, stovarsol, yatren, or some other drug, and as soon as the symptoms have abated and the stools are formed, dismiss the patient without further thought as to after-treatment or diet. . . . The brilliant and, at times magical temporary results that followed the introduction of emetin caused many to forget the relapses that so frequently followed. Emetin and its compounds must be used with discretion. . . . They are not drugs to trust to the patient himself, nor in untrained hands. They have a powerfully depressant and even toxic effect on the myocardium, and not infrequently produce a true paralysis of various groups of the voluntary muscles."

EMETIN

It is now recognized that emetin possesses so great a therapeutic hazard in *dosage required for effectiveness* in amebiasis that its routine clinical use in this disease is no longer justified. St. John [2] has recently demonstrated *in vitro* that amounts of emetin which are directly lethal for amebae are much greater than the body tissues can tolerate. It is a fact that clinically safe doses are not always sufficient to rid a patient of this infection, and that amounts in excess of 10 grains total (10 milligrams per kilo for the average adult) may produce permanent cardiac damage. The use of this alkaloid should be confined to amebic hepatitis or abscess, and to complicated amebiasis requiring surgical intervention, since other less harmful drugs are now available for the average uncomplicated case. When emetin is used, one should record the blood pressure and pulse rate daily. A lowering of pressure and an increase in pulse rate may indicate impending cardiac damage.

CARBARSONE

Of the less harmful drugs, the safest and most effective in our hands (in treating approximately four hundred cases to date) is carbarsone, an organic arsenical closely related to tryparsamid. We have used the drug orally and rectally in amounts totaling 2.5 grams per kilo, given over a year's time with no ill effects except in one case. Dr. J. C. P. Fearington [3] has employed a total oral dosage of 3.0 grams per kilo over forty-eight weeks with no perceptible harm. This is forty times the amount originally recommended by us [4] for the treatment of amebiasis. Thus far we have had but one case of intolerance to the commercial product now available. This occurred in an individual having an associated hepatitis with amebiasis (in which instance the drug should not have been given); after receiving 4.0 grams of the drug orally, the patient complained of intense right upper abdominal pain and soreness, generalized aches, weakness, and numbness of the hands and legs, but no nausea, vomiting, diarrhea, or cutaneous rash. Her sclerae were icteric, the skin dusky, and the liver edge descended 7 centimeters below the costal margin and was tender on palpation. Laboratory examinations were negative, except the rose bengal test, which at six minutes showed reduced elimination. Five days after discontinuing the drug, the symptoms cleared, and the patient is now in good health. This case was reported previously.[5]

VIOFORM

Vioform, N. N. R. (iodochloroxyquinolin), originally introduced as a dusting powder, was found more recently to be better than chiniofon ("yatren" or "anayodin") [6] in clearing patients of E. histolytica. In naturally infected monkeys it was the most effective of any of the drugs tried orally.[7] Clinically, vioform compares favorably with carbarsone. Our experience thus far is limited to ninety patients, three of whom have shown evidence of intolerance. Untoward symptoms (which may occur with as little as 4.0 grams of the drug) are severe gastric distress, with nausea, vomiting, colicky pains, diarrhea, excessive flatulence, with mucus and blood in the stools. When used rectally, severe local irritation results with concentrations as low as 1:500. Vioform should not be administered in retention enemata for this reason. Orally the drug is given in 0.25 gram capsules thrice daily for ten days (7.5 grams in the average adult), and after a ten days' rest this amount may be repeated.

PROCEDURE IN CLINICAL THERAPY

It is impossible to outline a definite routine for the clinical handling of the patient with acute amebic dysentery, but our procedure is, in general, as follows: After demonstrating E. histolytica, a

thorough examination of the patient is made, with special reference to hepatic and renal function and the extent of lower bowel damage (best observed through the proctoscope or in some cases with roentgenologic examination after barium enema). Only those individuals with extensive liver involvement, or other extra-cardiac surgical complications, are given emetin, as indicated previously. The average acute case with severe colitis may be started on retention enemata of carbarsone, 2.0 grams dissolved in 200 cubic centimeters of a 2 per cent sodium bicarbonate solution, to be retained over night for six consecutive times.[8] Meanwhile bismuth subcarbonate may be given in heaping teaspoonful amounts each time the patient has a watery or bloody movement. At the end of the first week, 0.25 gram capsules of carbarsone may be given two or three times daily for twenty doses. If symptoms clear at the end of this course, a week's rest is allowed. If not, the rectal therapy may be repeated, followed by a second oral course as above. Examination of the stools should be made at the end of the first month, and if negative no further oral treatment is indicated unless amebae reappear. During the first six months, series of specimens should be examined monthly, and after this interval stools should be searched at the end of each three monthly period for at least two years, and proctoscopic examinations should follows the progress of therapy.

If vioform is selected as the therapeutic agent, much the same procedure is followed, except that this drug must not be used rectally. The oral dosage is: 0.25 gram capsules thrice daily for a ten-day period.

CHRONIC AMEBIASIS

In chronic amebiasis, the more common form of the disease in California, rectal instillations are not usually resorted to. One may begin with capsules of carbarsone in 0.25 gram amounts twice daily for ten days, then allow a ten days' rest, following this with a second oral course totaling 5.0 grams. Vioform may be given in the same size capsule thrice daily. At the end of the first month of therapy, stools are examined as in the acute dysentery cases, and treatment is based entirely on the appearance of the pathogenic ameba in the stools. One other precaution necessary in any case of amebiasis concerns diet, which should be smooth (all vegetables pureed), low in starch, high in protein, and free from all alcoholic beverages.

AMEBIC HEPATITIS

Amebic hepatitis and hepatic abscess require emetin therapy, as suggested by Leonard Rogers.[9] The drug should be given subcutaneously in 1.0 milligram per kilo doses daily for ten days. When the acute symptoms subside and the liver function returns to normal, then carbarsone may be used safely, as outlined above for acute dysenteric cases. In hepatic abscess, however, aspiration should be resorted to *before* emetin is given, since patients recently emetinized are extremely bad surgical risks, in James' opinion.[10] It is believed, also, that aspiration is preferable to incision and open drainage in these cases, but surgical opinion on this point is not unanimous.

BISMUTH SUBCARBONATE

Bismuth subcarbonate is a most useful adjunct in acute dysenteric cases. Subnitrate of bismuth is not used because of possible untoward nitrite effects, such as methemoglobinemia and methemoglobinuria, following the administration of excessive amounts of the drug in susceptible individuals. Clark [10] has demonstrated healed amebic ulcers in patients who have died from other causes subsequent to bismuth therapy. Granulation tissue may fill the ulcer craters and the healed mucosa of the lower bowel seems to be capable of functioning. In some bismuth-treated cases the appendix is the only site at which amebae are found at necropsy. Cecal lesions being more accessible to the drug, heal before the lesions in the appendix, according to Clark's observations.

RESISTANT AMEBIASIS

Resistant cases of amebiasis constitute about 10 per cent of the group seen by us in California. Persistence in drug therapy, with special watch for ill effects in the heart (with emetin), liver or kidneys (with carbarsone or vioform), or blood (with bismuth *subnitrate*), is the keynote to a successful outcome. These individuals are real therapeutic problems, and one must be certain that reinfection is not nullifying drug action. Usually, however, there is a residual non-amebic colitis present which is, many times, refractory to specific therapy (if the causative organism can be identified), or to nonspecific symptomatic care (which is the case in the majority of resistant patients). Here surgical intervention may be warranted. Runyan and Herrick [11] advise cecostomy or, less frequently, appendicostomy followed by continuous irrigations of the large bowel. Ileostomy is preferred by some surgeons. The operation may be performed under local anesthesia, adding no further risk to the emaciated or dehydrated patient. Amebic granulomata of the bowel may occur and have been confused with malignancy. This requires surgical removal and *subsequent* specific amebic drug therapy, as emphasized by Gunn and Howard.[12] They state that "it is hardly conceivable that a pathologic process" like that of amebic granuloma "should yield to antiamebic medical treatment. Emetin hydrochlorid, while a very valuable remedy if properly used, is extremely depressant in overdoses and poorly borne in operative cases." Rectal ulceration also may act as a resistant focus, and on this account the infected area should be excised. Finally, one must not lose sight of the fact that other pathological changes may accompany amebiasis, such as malignancy, and thus confuse one completely in the clinical handling of these so-called resistant cases.

FAMILY THERAPY

The most important point regarding treatment is that it should be directed toward clearing the family, of which the sick person is a member, and in cleaning up the environment in which the patient lives, particularly because of possible reinfection. No therapy will be successful unless the simple matters of personal hygiene are controlled. In fifteen consecutive family groups, forty

of the total sixty-two members were found to harbor E. histolytica. In handling amebiasis, then, we must treat not only the patient who presents himself for care, but also treat *simultaneously* other infected members of his household, particularly the food handlers. Finally, one should always suspect possible fecal contamination of the water supply in any household harboring resistant cases.

SUMMARY

The response of the individual to E. histolytica infection is discussed with special reference to the added therapeutic hazard. The extent of tissue damage, the duration of infection, and the associated amebic or non-amebic complications determine largely the therapeutic approach. All members of amebic households should be examined, since multiple family infections are not uncommon. Those found harboring E. histolytica should be treated *simultaneously* with the patient who presents himself for care.

Carbarsone and/or vioform may be used in uncomplicated amebiasis in preference to emetin, because these drugs (1) may be given orally; (2) may be used in treating ambulatory patients; (3) are less toxic than emetin, especially for heart muscle; (4) have specific amebacidal action. Carbarsone has a definite tonic effect, and may be used rectally without causing local irritation as does vioform. Emetin is the drug of choice in treating amebic hepatitis, abscess or other surgical complications, and should be given *after* operation (when indicated) in total subcutaneous dosage not exceeding 10 milligrams per kilogram (10 grains for the average adult). Bismuth *subcarbonate* may be used in massive doses to control dysenteric symptoms during the acute stage (bismuth *subnitrate* is not used, because of possible untoward nitrite effect). Surgical intervention may be required in residual colitis cases, where through and through drainage is helpful, and in removing amebic foci in appendices, granulomata of the bowel and rectal ulcers.

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DISCUSSION

John V. Barrow, M. D. (1930 Wilshire Boulevard, Los Angeles).—The gist of this paper consists essentially in what the author chooses to call "The therapeutic hazards of the treatment of amebiasis."

We believe that the average case does not produce a very great hazard, either clinically or therapeutically. The severe cases are, first, essentially a very dangerous clinical hazard. They are the cases complicated with severe bowel ulceration and liver abscess. They are the cases in which systemic infection is another great hazard. In fact, they are the cases that may go on to fatal termination, in spite of all of our drug therapy and surgical intervention. They are the cases where the hearts bear a big brunt of the infection. Obviously any treatment, either mild or severe, cannot be held to bear the brunt of the results.

The author later limits almost all therapeutic hazard to the use of ipecac and its derivatives. He discusses "the dosage required for effectiveness" in a manner to indicate that that question is settled. Many of us do not regard the large doses of a medicine as the most effective use of that drug for therapeutic benefit. There is no question that large dosage of emetin is to be condemned. The same is true of all the other essential drugs in amebiasis. It seems odd to state that the use of emetin should be confined to hepatic damage, for here the patient faces the most severe hazard of the disease. If the drug is not a severe hazard in liver abscess, how can it be so dangerous in the very much milder forms? The author sets ten grains total dosage as the maximum above which we may expect cardiac damage. We make a mistake to set any fixed dosage up in opposition to the daily observation and clinical judgment of the physician. The same principal manifestly holds true for the arsenicals from which poisoning occurs much more often than from the use of emetin in the hands of careful clinicians.

I have nothing but praise for the arsenical mentioned by the author. It must be remembered that it is an "arsenical" preparation—a competitor of two or three similar remedies. I have used these arsenicals often, and were it not for constant watchfulness, I would see more cases of arsenical intolerance in one month than the author reports to have seen in his entire experience.

The chemistry of the oxyquinolin group has not been of unquestioned repute. No one would prescribe it for its benefit on white blood cell formation. This drug, also, must be given under sensible clinical direction.

In the author's concluding paragraph he states: "Emetin is the drug of choice in treating hepatitis, abscess or other surgical complications, and should be given after the operation (when indicated) in total subcutaneous dosage not exceeding ten milligrams per kilogram (ten grains for the average adult)." No one can truthfully say when a hepatitis begins in an amebiasis. Most workers believe a mild hepatitis exists in practically all amebiasis. Waiting for an abscess to develop before using emetin involves the same principle as waiting for an appendix to rupture and become walled off before surgical interference. Emetin in one-third grain doses, given from two to five times weekly, will protect the liver and thereby prevent abscess formation, if clinical experience is any criterion. So long as the patient is kept in bed, clinical watchfulness will guarantee that there shall be no clinical overdosage. The giving of one-grain dosage daily, in my mind, is not justified in these cases.

It is not the effect of emetin on the heart so much as it is the influence of the infection finding entrance through the amebic foci. The clinician must anticipate heart infection and heart strain in all acute diseases. If this is done and common sense is used in managing the treatment for amebiasis, there will be no cardiac failure in the administration of emetin.

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Herbert Gunn, M. D. (163 Twenty-sixth Avenue, San Francisco). — Doctor Anderson has dealt with important phases of the subject of amebiasis in an interesting, conservative and able manner.

There is no doubt that harm is often done by injudicious use of drugs in the treatment of this disease, as all of the drugs available are powerful and probably toxic in excessive doses.

The drug selected as the amebicide must be administered in sufficient dosage to accomplish its purpose—that is, the destruction of the amebae. In order to accomplish this without causing undue injury to the patient, it is necessary for the physician to have a thorough knowledge of the drug to be used. In addition, there must be available facilities for critical laboratory studies which not only govern the extent of the treatment, but represent the foundation upon which the entire case is built.

As stated by Doctor Anderson, emetin hydrochlorid is one of the most misused drugs in the treatment of this disease. It is powerful, and in overdoses toxic and dangerous. However, if properly understood and judiciously used, it is one of the most valuable drugs we have in certain phases of amebiasis. In the first place, it should be thoroughly understood that it is not amebicidal—at least in doses tolerated by the human body. A perusal of the literature will readily show that this statement represents the general view of the medical profession. However, I demonstrated the correctness of it myself and published my findings in the *California State Journal of Medicine* for May, 1918.

As stated by Doctor Anderson, emetin hydrochlorid is of great value in certain complications such as amebic hepatitis, liver abscess, etc. I believe, however, that we have no remedy that compares with it in controlling the dysenteric symptoms which occur in a certain percentage of amebic cases. Under such conditions the emetin is omitted as soon as relief from the dysentery is afforded and reliance placed in other drugs to complete the cure. The daily dose should not exceed one grain and, as stated by Doctor Anderson, a total of ten grains should not be exceeded. It has been my practice, in cases where it was believed advisable, to continue the emetin to reduce the dose to one-half grain after five or six days and later to one-third grain daily—the total amount not exceeding ten grains. Furthermore, no patient while receiving emetin hydrochlorid should be ambulatory.

For the radical cure of amebiasis—that is, the eradication of amebae from the body—dependence can be placed on two drugs, used alone or in combination with each other: the arsenicals and the iodin preparations. I have used an arsenical in the form of neoarsphenamin for this purpose for the past eighteen years. At first, it was used intravenously in conjunction with emetin hydrochlorid hypodermatically; later it was given as a retention enema instead of intravenously. Following the introduction of the iodin compounds, yatren and anayodin, I used neoarsphenamin by retention enema to supplement their action. The results of this treatment were highly satisfactory.

Carbarsone is undoubtedly an excellent arsenical preparation. I have used it in a number of cases, checking the results most carefully. It showed no toxic effects, was decidedly tonic in action, and the amebicidal effect was excellent. In addition, it is easily administered.

Of the iodin preparations, vioform I have not used. However, I have had considerable experience with anayodin and have found it an excellent preparation. The only disagreeable effect is at times a diarrhea which has been readily controlled by temporarily omitting the drug or reducing the dose. In chronic resistant cases I give anayodin continuously until two hundred pills have been taken. If tolerated, the dose is four pills thrice daily. This is supplemented by two or three retention enemas of neoarsphenamin given at weekly intervals; and 1.8 gram of neoarsphenamin dissolved in about 100 cubic centimeters of tap water is injected into the retum, to be retained. To facilitate retention, the patient should be in bed for four or five hours following the treatment; if the patient is ambulatory it is given at bedtime. No irritation of the bowel results. I have used this treatment successfully in at least one case which had proved intractable to four or five courses of carbarsone, extending over a period of several months.

I cannot agree with Doctor Anderson's statement that "reinfection is probably more common than relapse." From my experience, I believe that inadequate treatment or faulty laboratory technique can explain practically all recurrences.

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William C. Boeck, M. D. (1709 West Eighth Street, Los Angeles). — I have enjoyed the paper read by Doctor Anderson and the discussions by Doctors Barrow and Gunn, from which, apparently, there is something difficult and also mysterious about the treatment of amebiasis. Condemnation proceedings seem to have been instituted against emetin in favor of the arsenical compounds, especially carbarsone. It would appear that we have only learned how to treat amebiasis since the late advent of carbarsone, yatren, and vioform, but we lose sight of the work done by British and French physicians who treated with emetin thousands of cases during the World War. Some postpolemic therapeutists of amebiasis have sought to discredit emetin in favor of carbarsone, accusing emetin of producing permanent cardiac damage. Yet, they advise emetin in the treatment of amebiasis complicated by hepatic abscess—cases in which the heart has already suffered greatly from the prolonged toxemia produced by the liver abscess and the often associated amebic colitis. This hardly seems consistent.

There are many pharmacologic studies on laboratory animals that reveal the toxic effect of emetin on the heart when given in large doses. There is, however, only a scattering of cases of human amebiasis in which emetin was used with a resultant toxic action on the heart; and in these cases the electrocardiographic status of the heart was not known before treatment was begun. I am reminded of a remarkable series of over one hundred cases of amebiasis, acute and chronic, treated very carefully with emetin by Wenyon and O'Connor during the World War. In this series there were only two cases that manifested cardiac toxic effects, causing irregularity of rhythm and associated shortness of breath on exertion. The disturbance was not permanent, however, for it cleared up in two weeks. These patients received larger doses of emetin than are customarily advised today. One received 26 grains in twenty-seven days, and the other 30 grains in thirty-three days. Another case, however, received 46 grains in fifty-three days without any effect on the pulse rate, blood pressure, or rhythm of the heart. We may conclude, therefore, that some persons may have an idiosyncrasy to emetin as to quinin, arsenic, and other drugs. All of the other cases treated by Wenyon and O'Connor received from 12 to 30 grains or more of emetin without any toxic effect on the heart. When emetin was used in doses of one grain daily for a total of 10 to 12 grains in a course, such dosage produced no toxic effect on the heart in their experience; and that is the experience of many other investigators since the World War. Now, a shorter course of emetin, extending over four to seven days, is usually advocated, combined with the administration of either treparsol or carbarsone, vioform or yatren in treating cases with severe dysentery, but in chronic cases one may choose, if he wishes, one of the newer drugs and thus avoid the unpleasant hypodermic or intravenous administration of emetin.

Let us use the newer amebacides, since they are very efficient and easy of administration, remembering that they are not necessarily free of untoward results in some susceptible individuals, as reports have shown. Digitalis in too large doses is also toxic for the heart, but we do not stop using it because someone has been careless in its use with sometimes fatal results. I am certain that those physicians who wish to use emetin may do so without any risk to the patients if the proper dosage is followed. Let us remember, too, the thousands of cases that have been treated successfully, if not always readily cured, and feel grateful for what emetin has accomplished. It need not be ruthlessly outlawed for newer favorites that also have certain shortcomings and dangers. Good clinical judgment is still paramount no matter what the form of therapy.

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Doctor Anderson (Closing). — The first discusser, Dr. J. V. Barrow, has misread and misinterpreted the paper he is discussing. He is able airily to discard objective and authoritative laboratory studies in favor of his clinical impressions. With such a point of view, argument is unavailing. The paper does not "limit almost all therapeutic hazard to the use of ipecac and its derivatives." It reviews the therapeutic hazards of anti-amebic treatment from a point of view that willingly or unwillingly must receive attention from clinicians. To answer the particular points of criticism in this discussion is to repeat the contents of the paper itself, to which the impartial reader is referred. I would like to ask for exact case reports of intolerance to carbarsone, or other objective support for the statement that "were it not for constant watchfulness, I would see more cases of arsenical intolerance in one month than the author reports to have seen in his entire experience." Assuming that the discusser has this quantity of cases available, it would be desirable for him to give an exact detailed study of these intolerances, as such information would be helpful in evaluating anti-amebic treatment. The discusser's misreading of the final paragraph in the paper, referring to emetin as the drug of choice in amebic hepatitis, needs only a comparison with the original.

Probably a more dispassionate discussion, and one based on acquaintance with and recognition of the value of accurate experimental work, would have better served the purpose we have sought in the past five years' study of amebiasis, namely, the development of better methods of treatment, with no preference for any particular drug not based on its actual effectiveness.

Doctor Gunn's considered review must carry great weight with the clinician, as it comes from a very large clinical and laboratory experience.

I believe that if Doctor Boeck will read the papers of the last five years of our study of amebiasis, he will agree that full credit has been given to the excellent and classical work of British and French physicians. Also, a more careful reading by him of the paper now under discussion will answer most of his criticism. Many authorities could not agree with his statement that "there is only a scattering of cases of human amebiasis in which emetin was used with a resultant toxic action on the heart." Emetin, like any chemical acting on living tissue, has an effect proportional to dosage in terms of body weight. Evidence exists to show that it is fixed in cardiac and other muscle, and is very slowly eliminated from the body. It has, therefore, cumulative toxic properties. It injures heart muscle in doses below those required for effectiveness in amebiasis. The evidence for these statements has appeared from many independent observers during the last decade.

Emetin is recommended in amebic hepatitis, or when liver function is impaired in amebiasis, because other drugs less dangerous than emetin in the ordinary case of amebiasis, such as carbarsone or vioform, have themselves toxic actions on the liver, which might become serious in liver involvement. Emetin has no toxic action on the liver.

CERVICAL CANCER*

AN AUTOPSY STUDY OF WOMEN DYING WITH CERVICAL CANCER AFTER RADIATION

By Daniel G. Morton, M. D.
San Francisco

Discussion *by Homer Carlton Seaver, M.D., Los Angeles; Robert S. Stone, M.D., San Francisco; L. J. Tiber, M.D., Los Angeles.*

BEFORE the days of radiation, and while radical surgery was in its infancy, numerous studies were made of autopsy findings in women dying of cervical cancer. In 1858, Wagner [1] studied a number of such necropsies, and observed that many of the women were quite fat and failed to show the wasting commonly associated with advanced malignant disease. He found that marked ureteral dilatation was present in one-third of the individuals, and that only a few had metastases in distant organs. In 1893, Winter [2] conducted a similar study and made essentially similar observations. In addition, in forty-four autopsies after radical panhysterectomy (the growth well confined locally at time of operation) he found glands involved in only two. In 1895, Roger Williams,[3] in a beautiful study, reported findings in seventy-eight autopsies on women dead of cervical cancer. Extensive renal disease was noted in every case; definite hydronephrosis and hydroureter occurred in sixty-seven. Neighboring lymph glands were involved in fifty-six, or 72 per cent. Distant lesions were found in 20 per cent. He observed that the cervical cancer patient is usually cut off by intercurrent complication (*e. g.,* ureteral blockage), before the entire process has had time to mature.

THE TENDENCY OF CERVICAL CANCER FOR LATE METASTASIS

All of the earlier observers were struck by the absence of metastases in many of the far-advanced cases; they felt, therefore, that cervical cancer tends to metastasize late, that the actual cause of death is usually the local growth which kills by ureteral compression resulting in urinary insufficiency. They learned that the following sequence of events usually occur. The parametrium and vaginal mucosa are the first points of attack beyond the cervix, while coincident or shortly subsequent invasion of the bladder may occur. Spread to the uterine fundus and adnexa are usually late events. After growth in the parametrium, cancer cells may be carried to the regional lymph glands situated at the bifurcation of the common iliac artery, and called the iliac or hypogastric glands. Thence spread may occur to the lower lumbar glands along the vertebral column. When invasion of blood vessels takes place, distant metastases may occur to liver, lungs, and other organs. Usually, when death comes in the untreated case, the ureters have been blocked off by the local spread of cancer, metastasis may or may not exist in re-

* From the Woman's Clinic, University of California Hospital.

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gional lymph glands, and the woman looks well preserved in contrast to the emaciated, cachectic individual usually associated with advanced malignancy.

These studies are of immense value, for they teach us the natural history of the disease and enable us to form a picture of the process uninfluenced by treatment. Such observations were also of practical clinical value, for they suggested that radical surgery might offer hope of permanent cure in cases in which the local growth was early, it having been demonstrated that metastases were rare in such cases. This was borne out later when it was found that recurrences after operation were primarily local, not metastatic.

PURPOSE OF THIS STUDY

With these facts as background, it appeared to us that a study of autopsies upon women dead of cervical cancer in whom *radiation* had been employed as treatment might prove of considerable interest. Within the last year, Warren [4] and Behney [5] have each reported series of necropsies upon women who had died with cervical cancer. Warren's cases numbered 132 and Behney's 166. A considerable proportion of each had been treated by radiation. Each author brought out that metastases were found more frequently, the more anaplastic the parent tumor. Behney attempted to fix the cause of death as intrapelvic or extrapelvic in the 159 who actually died of cancer: eighty were due to extrapelvic conditions, and seventy-nine to intrapelvic. However, no distinction was made between the treated and the untreated. He found metastatic lesions in 55 of the 166 women. Unfortunately, neither of these authors attempted to correlate their findings with extent of disease when first treated, or with adequacy of treatment.

MATERIAL FOR THIS STUDY

A series of thirty-six autopsies on women treated for cervical cancer by radium, roentgen-ray, or a combination of both has been made by or for members of the department of obstetrics and gynecology of the University of California. Of these, sixteen were entirely adequate for study. The remainder, though quite incomplete in some respects, were sufficient to arrive at a satisfactory idea of the cause of death. Of the thirty-six, sixteen exhibited metastases, of which six were in regional or retroperitoneal glands only, and ten were multiple. The distribution of metastases is indicated in Table 1.

TABLE 1.—*Indicating Distribution of Metastases*

Lymph nodes		29 times
Retroperitoneal	13	
Regional	10	
Inguinal	2	
Mesenteric	2	
Femoral	1	
Mediastinal	1	
Intestines		7 times
Liver		7 times
Lungs		7 times
Pelvic bones		3 times
Vena cava		3 times

Adrenals, kidneys, gall-bladder, tubes, ovaries, mesentery, urethra, ribs, each once.

TABLE 2.—*Indicating Relative Frequencies of the Various Causes of Death*

Predominant Cause of Death	*Cases*	*Comment*
Local growth	22	Of which seven also had metastases
Distant or metastatic cancer	8	Of which five also had large local spread. Relative importance impossible to estimate
Accident or complication	6	
Total	36	

VARIOUS CAUSES OF DEATH

Some of the autopsies were limited in extent. Complete examinations of all cases might have revealed a few additional sites, as, for example, the brain. With the exception of bone metastasis, the sites indicated and their frequencies correspond fairly closely with those previously reported. Occurring three times in thirty-six autopsies, bone metastasis was far more frequent than has usually been found. The mere presence of metastasis, however, did not mean that it had played a prominent rôle in causing death. When an effort was made to determine the actual cause of death in each case, it was found that the local growth was responsible in the majority. The figures given in Table 2 show the relative frequencies of the various causes of death.

Death caused by the local spread of cancer was usually due to blockage of ureters with consequent hydroureter, hydronephrosis, uremia. Bowel obstruction was the cause of death in a few, and hemorrhage was responsible in one. Death due to metastatic cancer was similar to that observed in any case in which widespread malignancy has occurred—wasting, absorption of toxic products, interference with function of various organs, occasionally peritonitis. Those deaths classified as due to accident or complication will be commented upon in detail later.

An interesting and important point is that in only *one* case was there a total absence of local cancer. In other words, the radiation employed had failed to kill the local growth in all except one, and death from cancer would have occurred regardless of the presence or absence of metastasis. This fact points out rather forcefully how inadequate were the methods of radiation employed, and leads one to feel that there is much yet to be accomplished in the development of radiation as a means of treating cancer. It should be added that the methods and dosage of radiation conformed to those in use in the best clinics, except when some physical circumstance made them impossible.

TABLE 3.—*On Stages of the Disease, Metastases, Extent of Disease and Causes of Death*

Stage	*Cases*	*Metastases*	*Local Growth Cause of Death*	*Metastases Cause of Death*	*Accident Cause of Death*
Operable Cases					
1	4	2	1	1	2
2	7	4	2	2	3
	11	6 (54.5%)	3 (27.3%)	3	5
Inoperable Cases					
3	19	9	13	5	1
4	6	1	6	0	0
	25	10 (40%)	19 (76%)	5	1

ON STAGES OF DISEASE, METASTASES, EXTENT OF DISEASE AND CAUSES OF DEATH

Since conceivably radiation should have been *more* efficacious in those with small tumors than in those with advanced growths, correlation was attempted between the extent of the disease at first treatment and the occurrence of metastases at autopsy; and between the extent of the disease, and the cause of death. The findings are given in Table 3.

Metastases were found more frequently in the primarily operable cases, occurring in slightly more than half, as compared with two-fifths of the primarily inoperable.

It appears that those classed as 3 and 4, the more advanced cases and the least influenced by treatment, died, as a rule, because of the local cancer (nineteen of twenty-five). Metastases were found in addition in some, were the cause of death in a few. Although the number of early cases is small, death from local cancer seems to have been less prominent than in the more advanced groups. Several reasons for this suggest themselves: (1) the local growth is held in check by radiation, while metastases gradually take place and kill the woman; (2) the local growth is held in check, occasionally killed entirely, while metastases which have *already* occurred before treatment, grow and mature (this seems unlikely in view of the infrequency with which gross metastases are found at laparotomy upon operable cases); (3) the manipulation incident to biopsy and insertion of radium causes metastasis (this probably occurs in some cases, but is hardly the sole cause). The striking thing about the early cases (1 and 2) is the large proportion in which death was due to accident or complication.

REPORT OF CASES

Since these cases are of considerable interest, they are given in some detail.

CASE 1.—No. 67136, woman of fifty-three, died of an overwhelming urinary infection due to the presence of seventeen stones in the left ureter. The fatal infection occurred twenty-six days after completion of x-ray therapy, and was probably precipitated by it, since she had no complaints nor objective findings referable to either kidney before radiation, but was more or less ill from the beginning of radiation until her death.

* * *

CASE 2.—No. 70891, woman of sixty-three, died two weeks after the second of two radium treatments. She had received deep roentgen-ray therapy before radium. The second radium treatment was given in spite of a low-grade fever, which could not be explained; there were no specific complaints. Fever continued until death; there were no other findings except a low blood pressure. Autopsy revealed a mild bronchopneumonia, and extensive necrosis of the local growth, nothing else.

* * *

CASE 3.—No. 69483, woman of thirty-four. Died four months after completion of x-ray and radium therapy. During this time she was extremely ill with nausea, vomiting, persistent diarrhea, symptoms of partial bowel obstruction. She had had a laparotomy five years before. Finally, operation to relieve the obstruction resulted in a perforation of the sigmoid which was adherent to the left broad ligament, and shielded an abscess beneath it; peritonitis and death were the result. Death, however, had been inevitable for some time.

* * *

CASE 4.—No. 58562, woman of forty-three. Died six weeks after cervical biopsy and insertion of radium, of infected propagating thrombi in the pelvic veins, which had showered infected material to other organs, resulting in multiple abscesses.

COMMENT

Death in the first three of these cases (Nos. 67136, 70891, 69483) and possibly the fourth (No. 58562) must be charged up to radiation. Whether or not radiation *per se* was responsible may be open to question, the fact remains that the result of treatment was death. In Behney's series there were three patients who showed extensive destruction of the growth by radiation and died rapidly. Facts such as these show definitely that radiation carries an appreciable mortality—a mortality which has been overlooked in the general enthusiasm for this method of treatment.

There are several other features of these cases worth commenting upon. In the first case (No. 67136), well-preserved cancer cells were found in the cervix twenty-six days after radiation with radium and roentgen-ray had been completed. The ability of radiation to kill resistant cancer like this one, in spite of the small anatomical extent of growth, is called in question. In the second case (No. 70891) the inadvisability of continuing radium irradiation in the presence of fever is brought out. In the third case (No. 69483) the serious danger of radiating an area in which the bowel has become immobilized (by previous operation) is suggested. In the fourth case (No. 58562) is illustrated the occasional death which

TABLE 4.—*On Average Duration of Life After Treatment*

Dose		*Cause of Death Predominantly*			*Average Duration of Life After Treatment*
	Cases	Local	Metastatic	Accidental	In months
Adequate	21	12 (57%)	6 (28%)	3 (14%)	14.8 months
Inadequate	14	10 (71%)	2 (15%)	3 (22%)	10.7 months

will result from cutting into infected, partially necrotic tissue to obtain material for diagnosis. And last, none of these cases exhibited metastases.

Because "adequacy" of radiation conceivably should influence the subsequent course of the disease, and possibly the duration of life and type of death, correlation of these factors was attempted. For purposes of analysis, radium dosage was considered adequate if it exceeded 4,500 mch., or was particularly well distributed in and about the cervix, even if slightly less in amount. On the other hand, dosage was considered inadequate in some despite exceeding 4,500 mch. because of poor distribution (*e. g.,* all given against the cervix, none in the canal).

As may be seen from Table 4, metastatic carcinoma played the predominant part in death in a greater proportion of those adequately radiated than in those inadequately treated. Duration of life after treatment was appreciably longer in the well treated. These facts are not strange if one considers that in those inadequately treated the growth was less influenced, tended to behave as if not treated at all. If we recall the findings of Wagner, Winter, and Williams years ago, in untreated cases, the most usual cause of death was spread of the local growth and often a conspicuous absence of metastases. These figures are contrary to those of Behney, who found metastatic lesions in only 21 per cent of eighty *treated* cases, and in 44 per cent of eighty-six *untreated* cases. His figures are difficult to understand in the light of known facts.

Regarding those "inadequately radiated," one further point is of interest: in nine of the fourteen, proper treatment was not given because of a definite reason or hindrance. In four the reason was fever or acute illness; in two it was the conformation of the growth which made proper application impossible; in three the operator was unable to enter the cervical canal at all. These reasons for inadequate treatment are mentioned because they constitute a part of the problem of proper radiation in cervical cancer, and are likely to be encountered by anyone who treats the disease.

IMPORTANCE OF CAREFUL AUTOPSIES

While making this study it became apparent that autopsies are rarely performed as carefully as they should be. Unquestionably well-conducted postmortem examinations are of immense value, and may still teach us much; yet if they are performed in a routine manner, without special consideration of the particular condition present, valuable opportunities will be missed and many erroneous ideas may emerge. For example, unless microscopic examination is made of all enlarged glands in cases of cancer, there is no proof that these glands are cancerous. Indeed, it has often been shown that such enlargement is due to inflammation, yet all too often enlargement has been considered synonymous with metastatic involvement, not only by surgeons but by postmortem examiners. In our own series, this was true in a number of instances. Nor was it possible to tell from the reports of others whether or not "metastases" were confirmed by microscopic examination. As far as can be ascertained, no one has ever attempted to remove *un*enlarged glands for microscopic examination at necropsies upon cases of cervical cancer. Lack of attention to these details may have distorted considerably the picture which we now have before us.

SUMMARY AND CONCLUSIONS

A brief review is given of autopsy studies upon women dying of essentially untreated cervical cancer, and upon women treated by operation. These studies have given us a knowledge of the natural history of the disease. A study of thirty-six autopsies upon women in whom cervical cancer was treated by radiation is presented. The sites and frequency of metastases are noted. The most prominent finding as cause of death is correlated with the extent of the disease at first treatment, and with the "adequacy" of radiation. It was found that cases which were advanced when first seen usually died because of the local spread, and that metastases were frequently absent; this is in keeping with the findings of those who studied autopsies upon the untreated. Patients "adequately" radiated lived longer, and death was due more often to metastatic lesions—probably because the local growth was held in check, while metastases had time to occur, or those already present had time to mature and kill the woman. In only one case had radiation entirely destroyed the local lesion. In the "inadequately" radiated, the local growth was usually responsible for death. Attention is called to the mortality of radiation. Unavoidable reasons for "inadequate radiation" are given. A plea for more careful autopsies is made.

Third and Parnassus Avenues.

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DISCUSSION

Homer Carlton Seaver, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Morton has reported a most interesting survey of a subject which has received little attention in the past. A number of years ago I was impressed with the radium work of one of America's foremost pelvic surgeons, Dr. John Clark. For years he had discarded surgery in the treatment of cervical cancer and had used radium in all cases amenable to treatment. Living in a community where the vast majority of this work is done by general men who almost invariably do conservative (!) surgery, and having seen the end-result of a great many patients treated in this manner, I have followed the teachings of Clark. The essayist's paper shows the fallacy of adhering to such teachings.

Here, also, we are confronted with the problem of women going, or being referred directly by patients, to radiologists, the majority of whom have little grounding in pelvic diagnosis. It would be interesting to compare the end-results of their cases with those presented in this paper.

As is pointed out in the paper, cervical cancer, whenever possible, should be managed by men who are primarily gynecologists, but who also are able from practical training and experience to personally treat the disease, whether by surgical means, radium, or both.

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Robert S. Stone, M. D. (University of California Hospital, San Francisco).—The study of a carefully worked up series of postmortem cases is always educational. When such a study is accompanied by as good a critical analysis as has been presented to us, it is still more valuable. There are a few facts brought out by his study that I would like to emphasize.

Doctor Morton's series and those which he reviewed for us show that urinary tract complications are the greatest single cause of death. One wonders whether we pay enough attention to the condition of the urinary tract before starting, and during the course of treatments and the period of reaction. It has been shown very convincingly, and many times, that radiation is much less effective in the presence of an inflammatory reaction than it is when no inflammation is present. Because of this, most physicians treating cervical cancer make a sincere effort to clear up infections of the cervix before starting radiation treatments. I raise the question as to whether we are as careful of active or latent infections in the urinary tract. The ureters have a comparatively small lumen. Thorough, adequate radiation must cause a definite reaction in the mucosa of the ureters, as it does in the intestinal mucosa. This reaction, when added to an inflammatory reaction, may be just too much to allow proper functioning of these structures.

In the series reported, Table 4 shows that fourteen cases were inadequately treated, for various reasons. In only five of them was the cause the inability to properly place the radium, because of the configuration of the growth or the changes it had caused. I wish to point out here a fact of which Doctor Morton is well aware: that adequate radiation consists of both external and internal radiation; and that, if the external radiation is given first, the tumor often shrinks to such an extent that the internal radium application can be made much more adequately.

The fact brought out by Doctor Morton, that more of the primarily operable patients who were radiated died with metastases than the more advanced cases, does not answer the question as to whether the radiation caused the spread or not. Those patients lived longer, and had more time for metastases to mature, as he brought out. Also, the type of growth enters into the problem. It may be that they were of the type of growth that metastasizes, while the local growth is still small and, therefore, considered operable. If one observes the comparatively rapid degenerative changes which occur in a carcinoma after radiation, it is hard to imagine how the growth could metastasize at that period. It is also hard to imagine cancer cells encapsulated in comparatively avascular fibrous tissue such as we see some weeks after treatment, metastasizing more readily than the rapidly growing unencapsulated unirradiated tumor.

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L. J. Tiber, M.D. (3875 Wilshire Boulevard, Los Angeles).—The treatment of cervical cancer has undergone the usual extremes. In the days of Schauta and Wertheim, surgery was considered the one and only form of treatment. With the improvement in the use of x-ray and radium, the pendulum swung in the opposite direction, and the chorus began to sing the praises of radium and x-ray, and condemned surgery in the treatment of cervical malignancy.

One must admire Doctor Morton for his audacity to write an article wherein he proves that radium actually does not destroy the lesion *in situ*, and that metastases are more frequent than we are led to believe. He even dares to suggest that more careful autopsies should be performed with the possible result that the supposed success of radium therapy in cervical cancer, and perhaps in all cancers, might not be as superior to surgery as we have been led to believe.

One wonders whether more reports such as Doctor Morton has written will not demonstrate that surgery, in the proper hands, is not as valueless as is suggested in numerous reports on the success of radiation therapy in carcinoma of the uterus. We would then perhaps attempt to better our surgical technique in the treatment of cervical malignancies, and again prove that in the hands of well-trained gynecologists surgery, in advanced cases, gives as good results as radium, while in the early cases surgery properly done should be the treatment of choice.

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Doctor Morton (Closing).—It should be understood that no recommendation, nor condemnation, is being made of any particular method of treatment. As a matter of fact, most of the cases reported were comparatively advanced when first seen and no cure was expected. The stimulus for the study was the opinion of many authorities that present methods of radiation are quite adequate in destroying the local cervical growth, particularly in primarily operable cases, and that when death occurs it is due to metastases which have occurred before treatment. I was skeptical of the truth of this opinion and I believe that the present study bears me out, although I am well aware that metastases are responsible for death in a certain proportion of cases. Moreover, such an opinion leads us to be entirely too satisfied with our present methods of radiation. I feel that the problem is by no means settled. It is only by studies of this kind that a basis for well-founded opinions can be established. Although I agree that radiation is the *only* method of treatment worth considering for advanced inoperable cases, I do not think we should be blinded to the fact that it carries a distinct mortality and, like operation, it cannot always be carried out adequately. Let it not be thought that I oppose radiation as a method of treating cervical cancer; on the contrary, I believe it to be our most valuable agent in the vast majority of cases. I merely wish to point out that it has distinct limitations and that these limitations should be fully appreciated by all of us.

RELAPSING FEVER*

By LeRoy H. Briggs, M. D.
San Francisco

Discussion *by Arthur E. Varden, San Bernardino; George R. Magee, M.D., Yerington, Nevada; George E. Coleman, San Francisco.*

IN 1922 we reported[1] the first two cases of relapsing fever occurring in California, thereby demonstrating the second endemic focus of the disease in this country. Subsequently,[2] a third has been discovered in Texas. Since then such an increasing number of cases have arisen in this State and adjacent regions in Nevada that, in 1931, the California State Board of Health wisely made it a reportable disease. The object of this communication is to review all the cases reported in these two states between 1921 and 1934, amounting to sixty. Two additional were discovered in Salt Lake City in 1933; but as they took their origin in Nevada, they are included, bringing the total up to sixty-two. Doubtless many others have arisen—some possibly recognized as such and not reported—but in this survey, questionnaires were sent only to physicians so reporting. Of the sixty-two, there were thirty-nine in California and seven in Nevada, in which the parasite was demonstrated and diagnosis made beyond question. Of the sixteen unproved cases, all from California, two unquestionably were positive, as the patients were living in close association with proved cases, and came down simultaneously with exactly similar illnesses. Five more corresponded so closely clinically that they are included, even though smears were negative in three of them. Nine cases were so doubtful that they are not considered at all. A recapitulation follows, therefore, of fifty-three cases.

THE PARASITE

The spirochete of relapsing fever is characterized mainly by its pleomorphism, and it is impossible to separate different species morphologically. Coleman[3,4] is doing extensive work at the Hooper Foundation of the University of California in attempting a serologic separation of various varieties, and feels that some strains from different foci in the State are identical, and even possibly the same as the Texas strain. From the practical standpoint, the parasites are recognized as readily in blood smears stained by any Romanowsky method as are plasmodia, although it must be remembered that the organism is extra-cellular.

TRANSMISSION

It has long been known that the spirochete of relapsing fever frequently is transmitted by ticks of the Ornithodorus variety, both adult and nymph, the transference being effected, not by the actual bite, but by the rubbing of contaminated feces or other secretions of the tick into the wound. At the time the two first cases were reported from Polaris,[1] we felt that the most likely agent producing the body bites was the bedbug, as no ticks of the Dermacentor variety were found, and the bites certainly were not those of the adult Ornithodorus coriaceus. It was not known then that ticks of the Ornithodorus species were present in that region, but a short time later Boyd[5] of the Rockefeller Foundation pointed out that Ornithodorus talaje had been identified as far back as 1914 within a few miles of Polaris. It is this variety that has been incriminated as the vector of relapsing fever in Panama.[6] In the Texas cases Ornithodorus turicata was identified as the vector, and this species as well has been found in the country about Lake Tahoe. It is not at all improbable, therefore, that one or the other species, or both, may be the vector, although as yet only a few specimens have been taken, and no spirochetes have been demonstrated within them. The louse, which figures so largely in the transmission of relapsing fever in other parts of the world, very probably plays little part as yet in the spread of the disease here in the West.

Another factor to be considered in the dissemination is the rodent, which may act as the reservoir, or simply as another host both for the parasitic spirochete and the ectoparasitic tick. A joint study is being made by the State Board of Health and the Hooper Foundation of the various rodents in the Sierra Nevada Mountains for the presence of spirochetes, and positive results so far have been obtained from chipmunks and squirrels.[7] The final links in connecting up the spirochete, the tick, the rodent, and the human have yet to be forged.

SEASON

Inasmuch as the present distribution of the disease occurs in a region for the most part given over to recreation, and at an altitude where considerable winter snowfall is the rule, the greatest incidence is in the summer months. Influencing this also may be the fact that many of the small animals which may act as the reservoir hibernate during the winter. Of the group, there was one in March, two in April (one of these a laboratory infection), one in May, twelve in June, sixteen in July, fifteen in August, five in September, one in October, and none in November, December, January, and February. (Figure 1.)

SEX AND AGE

There were thirty-four males and seventeen females, with sex unstated in two cases. The two-to-one predominance in the male probably is due, not to any sex susceptibility, but to the greater chance man runs of acquiring an animal-borne, out-of-door disease.

There was a wide variation in age, ranging from four to sixty-six years, with the average age thirty-two and a half. Fourteen were in children of fifteen or under.

LOCALITY

So far this seems to be a geographically limited disease, and especial attention has been directed

* Read before the General Medicine Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

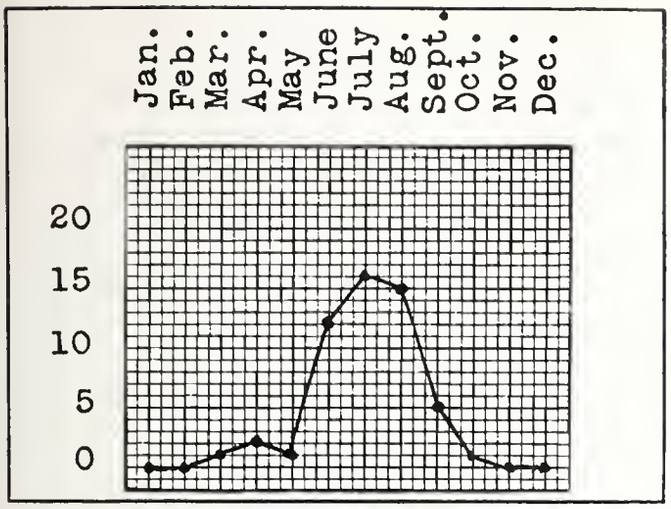


Fig. 1.—Incidence of relapsing fever by months.

to the location where the infection was acquired. The forty-six California cases were limited to three National forests,—the Eldorado, the Tahoe, and the San Bernardino—with the bulk of them coming from the immediate vicinity of two great natural playgrounds—Big Bear Lake, and Lake Tahoe. These two areas appear to be the main endemic foci in the State, probably largely on account of their more dense summer population. Two cases came from the lake region near Sierra City, approximately forty miles northwest of Tahoe, and one from Pine Crest, a vacation resort in Tuolumne County, fifty miles south of Tahoe. Three patients were traveling and camping out, two in the Tahoe region, and one in the mountains in the southern end of the State, and one other case was a laboratory infection, acquired while working with infected mice. One patient was said to have been infected in the mountains "about one hundred miles from Salt Lake City," with no more geographic details available.

Twenty-two cases came from the country around Big Bear Lake, lying in the mountains of San Bernardino County at an altitude of 6,600 feet, and another from Arrowhead Lake, twenty miles adjacent and 1,500 feet lower. Most of these were under the care of one physician, Dr. W. E. Williams, to whom I am greatly indebted for his painstaking observations and personal communications.

Of the fifteen cases from the Tahoe region, twelve came from the north end of the Lake, which lies at an altitude of 6,200 feet. Two came from Polaris on the Truckee River, about twelve miles north of the Lake, and one from Echo Lake, a small lake 7,500 feet high, on the summit just southwest of the lower end of Lake Tahoe.

Of the seven Nevada cases, five were from three small towns situated in a large valley devoted to agriculture some sixty miles east of Lake Tahoe, at an altitude of about 4,500 feet, at the eastern foot of the Sierra Nevada Mountains. The other two persons with infection, picked up in Salt Lake City, were rather indefinitely located as having acquired the disease in the Humboldt Mountains, a short distance east of Lovelock.

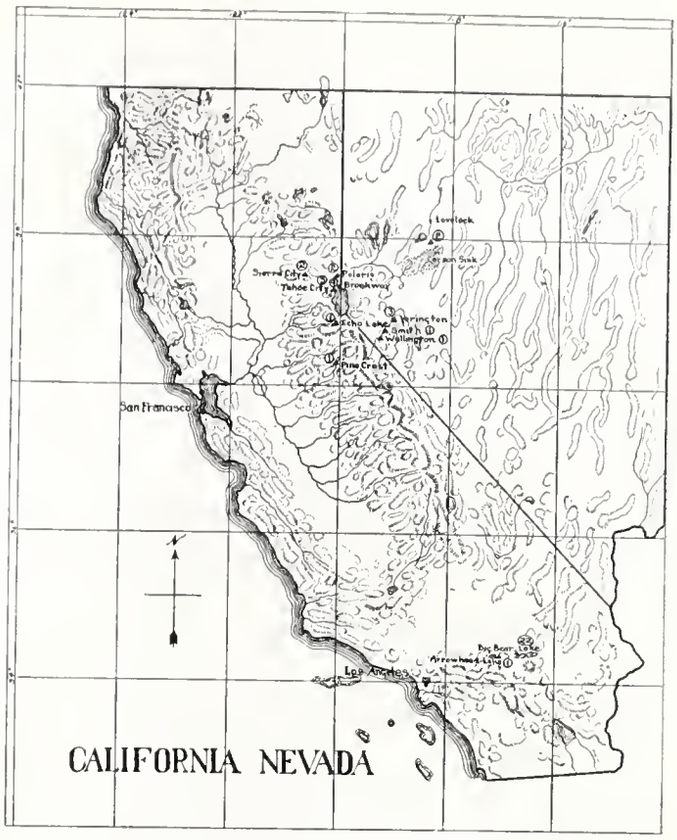


Fig. 2.—Indicating localities where relapsing fever has been found.

The California and Nevada locations are shown on the map in Figure 2.

ALTITUDE

The altitude varied from 4,200 to 7,500 feet, with the great majority around 6,500 feet. When more is learned of the animal reservoir and the vectors, this matter of altitude may have considerable significance in regard to the distribution of the disease.

INCUBATION TIME

Naturally, little definite can be said on this, as no absolute knowledge is had regarding transmission; although, as has been mentioned, it is felt that in many instances the parasite is introduced into the blood by the bite of the adult tick or its nymph. Insect and tick bites were noted in twenty instances; and assuming that this was the mode and time of infection, the average incubation period was seven and six-tenths days. In one case, already reported by Legge,[8] definite data is available. The patient was a field worker for the California State Department of Public Health, engaged in the collection of suspected infected rodents in the mountains. He experienced no insect bites, but on one occasion contaminated open lesions of his hands with animal blood proved to be infected with spirochetes, and eight days later his attack started. In the first two California cases reported,[1] the patients, very careful observers, in each instance noted marks of bites on the body eight days before the onset of fever. In the cases reported by Weller and Graham [2] from the Texas focus, the incubation period was six and seven days.

PAROXYSMS

As the name indicates, the relapsing or recurrent nature of the fever is its chief characteristic. In these fifty-three cases the number of attacks varied from one to twelve, averaging 3.3 per patient. When the disease becomes better known, diagnosis should be made earlier and the number of paroxysms materially lessened by prompt treatment. In five patients who received no treatment, the average number of attacks was 4.5 per patient. The duration of the febrile period was from twelve hours to nine days, with the average two and seven-tenths days. A frequent observation was the progressive diminution in the length and severity of the paroxysms, the infection in many instances apparently tending to burn itself out. Fever ranged from 100 to 106, the average maximum being 104, with an afternoon fastigium in the majority of instances. The length of the afebrile periods varied from three to thirty-six days, with an average of eight and three-tenths days.

SYMPTOMATOLOGY

There is nothing especially characteristic about the clinical picture, which is that usually associated with any acute generalized infection. Like the fever, the onset is abrupt, the maximum intensity of discomfit being reached within twenty-four hours. The incidence of various symptoms in the group may be tabulated in round numbers as follows:

	Present Per Cent	Absent Per Cent
Chills	84	16
Sweats	82	18
Generalized aches and pains	82	18
Malaise	80	20
Nausea and vomiting	74	26
Headache	50	50

Obviously, therefore, there is nothing in the patient's story except for the locale and the possible history of insect bites that is diagnostic of anything but an acute infection of some type.

PHYSICAL SIGNS

The same may be said for the physical examination. One finding that occurred in a third of the cases was a moderate enlargement of the spleen. Other signs are tabulated as follows:

	Present Per Cent	Absent Per Cent
Enlargement of spleen	33	67
Jaundice	18	82
Enlargement of liver	14	86
Herpes	14	86
Eruption	4	96

The Blood.—Blood counts were recorded in about half the cases, and showed nothing but a slight anemia, as can be seen by the table:

	Hemoglobin (Per Cent)	Erythrocytes (Millions)	Leukocytes	Neutrophiles (Per Cent)
Average count	79	4.4	9,700	70
Extremes:				
High	95	5.6	18,000	90
Low	50	2.5	5,200	40

These figures are based on twenty hemoglobin and red-cell observations, thirty-two leukocyte and twenty-six differential counts.

Apart from any morphological change, the blood offers the only positive avenue for diagnosis by the demonstration of the parasite. This is usually readily enough found in stained smears taken during the paroxysm, and examined under the high power. If these facilities are not available, however, a small amount of blood taken in citrated normal salt solution and sent to any laboratory will prove infectious to mice even after several days have elapsed. One or the other of these two methods should always be done in the suspicion of the disease, if a proper knowledge of its distribution and scope is to be obtained.

The Urine.—Urine examinations were done in thirty-five cases; and in sixteen, or 46 per cent, albumin was found, while ten, or 29 per cent, showed casts. This is not incompatible with any acute infection marked by high fever, even of short duration.

TREATMENT

Since the arsenicals are specific in most spirochetal disease, the drug of choice was neoarsphenamin given intravenously. Nothing else in the series was used as specific therapy, although various symptomatic measures were tried occasionally. Forty-six of the cases received ninety doses of arsphenamin, averaging 0.43 gram to the dose, with the average number of doses to each patient being two. It is significant to note that twenty cases received but one injection each, averaging 0.45 gram, without any relapses. In eight cases a single relapse followed specific therapy. In two of these an adequate dose was given in an afebrile period, and a subsequent dose during the relapse terminated the disease. In three more the initial dose was 0.15 gram, in one 0.3 gram, and in two 0.45 gram, although in one of these last the matter of the subsequent relapse is questionable. From these results it would seem, therefore, that 0.45 gram given during the febrile period, while the spirochetes are in the blood stream, is sufficient to terminate the infection.

IN CONCLUSION

If we may draw a composite picture of the disease then, we find a person living in an endemic area during the summer months who may have been bitten by a tick or have had the broken skin contaminated by the blood of certain rodents. Seven or eight days later, he becomes acutely ill with high fever, chills, sweats, malaise, generalized aching pains, nausea and vomiting. An examination may reveal an enlargement of the spleen, but little else. Blood examination, if it does not show parasites, is approximately normal, and the urine may contain small amounts of albumin and casts. After about three days the fever

subsides, only to have the cycle repeat itself at seven- or eight-day intervals, the paroxysms tending to become less severe as time goes on. Should parasites be found and diagnosis made, an injection intravenously of 0.45 gram of neoarsphenamin during the febrile period will suffice usually to effect a permanent cure at once.

The disease is important to recognize, not only because of its epidemiologic significance, but because much time may be saved the patient by prompt treatment. Once again should be stressed the importance of a proper blood examination of all patients taken acutely ill in an infected region.†

384 Post Street.

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DISCUSSION

Arthur E. Varden, M. D. (575 Fifth Street, San Bernardino).—I think that we are all indebted to Doctor Briggs, first for reporting true relapsing fever in California, and now for summarizing all of the cases so reported, giving us a picture of this disease as it occurs here in the West. One can add very little to this splendid paper.

Barnister, in 1930, reported a case of relapsing fever arising in Arizona, thus adding another endemic focus in this country.

In India, human carriers of relapsing fever have been found. We were suspicious of one patient in Big Bear Valley of being a carrier, but attempts to prove this to be true were unsuccessful.

In regard to treatment, Manson, in his book of tropical diseases, warns against treating patients during the height of the fever because of the possibility of a severe reaction due to the sudden liberation of endotoxins. I have had one such reaction, and since then have advised treatment during the time of fervescence. Treatment at this stage is most successful. In children 0.15 of neoarsphenamin appears to be a satisfactory dose.

In conclusion, I want to emphasize again what Doctor Briggs has said: that early in the course of the disease there are no symptoms or signs peculiar to relapsing fever, and that one must keep in mind the various foci of infection in order to make an early diagnosis. Any patient with an unexplained fever coming from one of the infected areas should have proper blood preparations made and search instituted for the spirochete.

George R. Magee, M. D. (Yerington, Nevada).—A study by Doctor Briggs of the present status of relapsing fever is welcome.

It has only been nineteen years since Meader reported the first endemic focus in the United States, located at Bear Creek Canyon in Colorado. The report of two cases from Polaris, on the Truckee River, in 1922 by Doctor Briggs has stimulated interest in the disease in the far west, and was directly responsible for the discovery of the disease in western Nevada.

The first proved case of relapsing fever in Nevada was seen in June of 1930. Whether we are dealing with a disease that has recently been imported is difficult to say. Its antiquity may be suggested by the fact that the disease has never been seen in a full-blooded Piute. These people are exposed to the disease more than are the white inhabitants.

We do not know how many paroxysms occur before the disease runs its course in untreated cases. We have seen cases in the fifth and sixth paroxysms, and the patients claimed they were more severe than the preceding ones.

In our hands neoarsphenamin is most efficacious if administered at the beginning of the febrile period.

A preliminary epidemiological survey has been conducted by workers from the Hooper Foundation, but no definite vector or rodent has been linked with the disease.

George E. Coleman (Hooper Foundation, San Francisco).—In this short paper Doctor Briggs has well concentrated the salient features of interest to the clinician concerning relapsing fever in California. In considering the early history of any disease which has apparently such a low morbidity (and we have really only begun to study this disease in California), it must be remembered that its diagnosis is not always so easy as would appear. I have an idea that many cases have been overlooked, or patients with mild symptoms have not sought the advice of physicians. In the first place, the onset does not always cause such severe or wholly typical symptoms as subsequent relapses. In my own infection, during the first days I was not conscious of headache, fever, chills or sweats, but I did suffer the most excruciating neuritis in my legs. A few days later when these symptoms had subsided and the others appeared, my blood was positive and the strain was transferred to mice. It is probable that this was during the first relapse. I believe there may be cryptic or aborted infections in which spirochetes may either not appear in the blood or a minimal number only be found in thick smear. For this reason, the blood of a patient whose residence in the Sierras and symptomatology give a suspicion of relapsing fever should be examined several times if negative and, better still, one to two cubic centimeters of blood, especially if negative, should be drawn and inoculated intraperitoneally into mice. I do not know if the physicians practicing in such an outstanding endemic center as Big Bear Lake keep a few mice on hand for this purpose, but I believe that in order to save time this would be a good idea.

Doctor Briggs has given the average incubation time as 7.6 days. If my own infection incurred (perhaps from rodent fleas) while autopsying squirrels, it was after eleven to thirteen days; if a laboratory infection, it was eighteen days. In the latter case I pricked my finger with an empty pipette which had contained first relapse blood (one spirochete in fifty microscopic fields). The usual prophylactic measures were taken.

The epidemiology of the disease deserves far more intensive study than it has thus far received. We do know that several tick species, notably O. turicata and O. talaje, vectors of relapsing fever spirochetes elsewhere, lead a parasitic existence in the Sierras. Doctor Briggs has reminded you that O. turicata is the vector of the Texas strain. I have already shown

† It gives me the greatest pleasure to thank the physicians who so cheerfully coöperated in filling out the questionnaires, and especially Miss Ida M. Stevens, epidemiologist of the State Board of Health, for her invaluable assistance.

that immunologically these strains are very closely related to, if not identical with, some at least of the California strains. It is highly probable, therefore, that this tick will be incriminated as a natural vector in this State. However, I am not yet convinced that other arthropods should be ruled out. We do not really know whether California strains are gradually becoming adapted to the body louse, to rodent or other fleas, or to bedbugs. Then, too, there are in the mountains many other arthropods of which man might become the transient host, and which might infect by biting or otherwise. We are not justified in assuming that ticks are or may remain the only vectors. We require further surveys and accumulated facts.

Without in any way wishing to appear as an alarmist, it should be remembered that while in this State man is now merely an accidental host, given the proper conditions epidemics could occur. Not only in Africa, but on the American continent severe epidemics are known to have been caused at various times by spirochetes of relapsing fever transmitted by ornithodorus. These epidemics have occurred in Mexico, Panama, Cuba, and most of the countries in the northern and eastern part of South America.

I would suggest that visitors to the Sierras be cautioned against all biting insects and, in the interest of science, be asked to attempt to obtain, alive or dead, the insect by which they believe they may have been bitten.

*

Doctor Briggs (Closing).—In regard to the use of a single fairly large dose of neoarsphenamin at the height of the fever, it is quite true that considerable reaction may and does occur from the liberation of protein in the killed spirochetes; but this rarely does more than make the patient ill for a few hours, and is counterbalanced by the fact that the spirochetes are more completely killed by a single large dose than by repeated smaller ones.

The disease certainly is increasing or at least being more widely recognized, as evidenced by the number of cases of this year; and already a new focus has been established in British Columbia.

MECHANISM OF CARBON DIOXID THERAPY*

WITH SPECIAL REFERENCE TO THE LUNGS

By A. J. Wineland, M. D.
Los Angeles

Discussion *by Eldon W. Tice, M. D., Los Angeles; W. V. Chalmers-Francis, M. D., Los Angeles; John Miller Wilson, M. D., Pasadena.*

THOSE of us who have been responsible for carbon dioxid therapy have used several methods of administration, with gratifying results in some cases and failures in others, and have observed that an ill-advised routine method is oftentimes detrimental to the well-being of the patient. We have also learned through experience that this type of therapy may only be used to advantage in cases of pneumonia, postoperative atelectasis, and resuscitation. Also, that the length of time during which the treatment is beneficial may be limited. It is with these thoughts in mind that we shall discuss the action and administration of carbon dioxid gas in the treatment of lung conditions.

*Read before the Anesthesiology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

ACTION OF CARBON DIOXID

The factors of greatest importance in the mechanism of carbon dioxid action are hyperpnea, bronchial dilatation, and stimulation of the respiratory center.

Hyperpnea is developed as the carbon dioxid tension in the blood is increased, and the respiratory center thus stimulated. Inasmuch as the diffusion of the gas follows the law of the partial pressure of gases, an increased blood tension may be obtained by increasing the alveolar carbon dioxid. By producing an active hyperpnea in such a manner, the per minute volume of respiration may be doubled readily. For our purpose this accomplishes the following:

First: It activates the pulmonary circulation, diminishing circulatory stasis in the lung tissue, and aids materially in the prevention of hypostatic conditions.

Second: It forces air into the terminal bronchi and alveoli, lessening the extension of an atelectatic process.

Third: It provides a sufficient volume of air to remove the mucus in the terminal bronchioles, where atelectasis is in the process of establishment.

According to Brown,[1] the effect of carbon dioxid on the bronchial tree is that of bronchodilatation. Cannon's [2] and Lintons' researches show that muscle metabolites, of which carbon dioxid is a very important one, produce the dilatation by stimulation of the sympathetic nervous system. The capacity of the bronchial tree, or dead space of the lung, is increased from an average of 140 cubic centimeters to an average of 600 plus centimeters. This accomplishes the following:

First: It lowers the resistance to the passage of air into and out of the lungs. This assists in forcing air into the collapsed alveoli on inspiration.

Second: It assists in dislodging obstructing material from the terminal bronchioles, and thus restoring the alveoli to active function.

In addition to the above-mentioned factors, carbon dioxid has an effect on the cardiovascular system. This is manifested by a sudden rise in the systolic blood pressure, causing an increase in the pulse pressure. The pulse rate also becomes increased, following the rise in systolic pressure.

PRELIMINARY MEASURES

Complete physical examination of the patient should always be made. This should give sufficient information concerning the lungs to make a definite diagnosis as to the nature of the pathological process, and establish the presence or absence of cardiac decompensation and displacement. The location of the apex beat should be marked on the chest wall. Changes in its location will assist in the diagnosis and prognosis as treatment is given; also it will aid materially in detecting any degree of cardial dilatation in aged patients.

Any interference with the normal respiratory exchange will produce clinical pulmonary pathology. The development and extent of this pathology is dependent upon the degree of interference and the length of time such has existed.

Before beginning the administration of carbon dioxid to a patient, it should be determined whether or not his respiratory difficulty is due to:

First: Central depression of the respiratory center, by hemorrhage, embolism, or tumor.

Second: Injury to the motor nerves of the respiratory muscles.

Third: Reflex inhibition due to pain, as from pleuritis, or peritonitis.

Fourth: Mechanical obstruction; from hypostatic pneumonitis, hypersecretion and accumulation of mucus within the bronchi, foreign bodies, postural position, abdominal distention or obesity.

The pathological sequence is essentially the same regardless of the cause, and consists of the obstruction of a small bronchus or bronchiole by pressure from without, as in hypostatic conditions, or by mucus from within, which prevents respiratory exchange taking place in the distal alveoli. The absorption of air from these blocked alveoli results in atelectasis. This becomes infected and as the concentric inflammatory process extends, more bronchi become obstructed and more lung tissue involved.

The effect of carbon dioxid on the cardiovascular system is of importance in patients having a weak myocardium, aneurysm, or atheromatous arteries. Those having cardiovascular changes of this nature should be carefully ventilated, because acute dilatation of the heart or apoplexy may result. Forceful hyperpnea in the aged should not be developed because of the likelihood of these complications. If decompensated heart disease exists, carbon dioxid, or carbon dioxid and oxygen mixtures should be used with caution.

ADMINISTRATION AND TECHNIQUE

The attitude of the patient during administration should be a comfortable dorsal position, with the head extended sufficiently to facilitate free respiratory exchange. The lateral recumbent position may be used effectively, if there is only one lung involved. The foot of the bed should be raised sufficiently to put the patient in a slight Trendelenburg position, unless otherwise contraindicated. This can be done so that there is appreciably no pressure of the abdominal viscera on the diaphragm and aids in the drainage of secretions from the bronchial system.

Various techniques are used for administering carbon dioxid, or carbon dioxid and oxygen mixtures. These include the use of masks, tents, nasal catheters and gravitation as conveyors of the gas to the patient. Carbon dioxid by itself should never be administered by any other method than open gravitation. Oxygen containing from 5 to 10 per cent carbon dioxid may be administered by means of the mask, tent, or nasal catheter. From the patient's psychic standpoint, however, it is better to use the open gravitation method.

Due to the great variability in response of patients to carbon dioxid, the dosage must be determined by the individual reaction. In cases of extensive pulmonary involvement, the initial dosage should be small, and should be increased gradually to the desired point of respiratory volume. Gradual increase in dosage will produce an active hyperpnea with a productive cough. Beyond this point signs of overdose may appear, and administration should be discontinued.

Objectively, overdose first manifests itself by producing dyspnea. If administration is continued, the patient passes into a state of semiconsciousness during which time involuntary contractions of the muscles of the body may occur. The eyelids are drawn open and remain so, and the pupils become dilated. A state of apnea may develop, during which time the pupils are widely dilated and the skeletal muscles become rigid. This state usually terminates with a general convulsion of short duration. The patient may, or may not, become cyanotic during this period.

The gravitation method of administration is the procedure of choice in the opinion of the author. Administration to infants should always be made with a mixture of oxygen and carbon dioxid. Carbon dioxid is used only for administration to adult patients. Being one and five-tenths times heavier than air, it will readily fall from a height of three to four feet and increase the content of the inspired air sufficiently to produce a mild degree of hyperpnea. By decreasing this distance, any desired degree of hyperpnea may be obtained. When the desired degree of hyperpnea has been produced, the administration should be temporarily discontinued. In cases requiring increased respiratory activity for a long period of time, the flow should be delivered from a fixed height.

TREATMENT

Before carbon dioxid therapy is administered to a patient, the causative factor for the interference with respiratory activity should be determined. In postoperative atelectasis, the duration and frequency of the treatment should be determined by the severity of the case. Those in which physical examination reveals an abundance of transudate in the bronchial tree may require treatment to the point of producing a productive cough every fifteen minutes. As the transudate is removed, this interval may be lengthened to thirty or forty-five minutes. Short intervals cause the patient to become fatigued and, therefore, it is best to increase the interval time as early as possible, during the course of the treatment. If on physical examination there is evidence of a nonaerating portion of the lung, and no evidence of transudate in the bronchial tree, one should consider that an exudative process is present. There should be no attempt made to break up an exudative process by forced respiratory activity, but this does not mean that treatment should be discontinued. Administration should be continued at intervals of one to two hours for so long a period as is necessary to prevent extension of the pathological process in the lung. This may mean until resolution of the exudative process takes place, and may require treatment for several days.

In pneumonia and pneumonitis, carbon dioxid therapy should be instituted early, and the degree of hyperpnea produced should be mild and not forced.

In treating the newborn, or infants, for resuscitation or atelectasis, extreme caution should be taken. Only mixtures of carbon dioxid with oxygen should be used. Production of hyperpnea should not be attempted in the child who is able to cry out and continues to aerate his lungs. The crying effort in itself will correct practically every case of atelectasis in the newborn.

IN CONCLUSION

The factors of chief importance in the mechanism of carbon dioxide action are: the production of hyperpnea, bronchodilatation, and stimulation of the respiratory center.

Carbon dioxid therapy is of greatest benefit in the treatment of pulmonary conditions in which pathological transudates are present.

Physical examination is imperative for diagnosis and treatment.

The open gravitation method of administration is preferable to other methods.

Carbon dioxid may be administered to adults, but should not be administered to infants without the addition of oxygen.

Administration of carbon dioxid should be avoided in patients having cardiovascular conditions in which a sudden rise in blood pressure might cause injury.

The patient should be carefully observed for the development of dyspnea, and the administration stopped as soon as this objective symptom is noted.

338 South St. Andrews Place.

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DISCUSSION

Eldon W. Tice, M. D. (704 Hillstreet Building, Los Angeles).—It is the anesthetists on whom we depend for the therapy and uses of the various gases we have at our command. I wish to compliment Doctor Wineland on his excellent paper, and am glad that he has stressed the necessity for the use of carbon dioxid in chest conditions.

It must be borne in mind that any consolidated area in the lung should not be disturbed, but enough carbon dioxid given to prevent the further collapse and consolidation of the surrounding lung tissue. There are some cases in which the desired hyperpnea can readily be obtained, and there are others in which the giving of carbon dioxid produces at once a dyspnea; and in these cases the use of carbon dioxid not only is of no avail, but does the patient harm and so should not be employed.

It is the opinion of a good many surgeons that the so-called "postoperative chest" can be prevented by the proper use of carbon dioxid following the anesthetic. We must remember that the preoperative narcosis, plus the anesthetic, depresses the respiratory effort, and a lack of ventilation of the lungs, regardless of the cause, is very liable to give trouble.

The proper use of carbon dioxid with oxygen in the resuscitation of the newborn is something that every obstetrician and anesthetist should know. In checking up the newborn deaths in various hospitals, the lack of use of carbogen with the tracheal catheter was very apparent. At the Los Angeles Methodist Hospital last year, about six hundred babies were brought to birth, and of this number, twelve were newborn deaths, six were premature, in two cases the infants required operative procedures, and one was a monstrosity, leaving three cases in which more might have been done to keep the infant alive. In one of the hospitals of a neighboring town there were about 360 babies delivered and thirty-six deaths of infants. In only one case was the tracheal catheter used or attempted to be used. The use of the tracheal catheter, with carbon dioxid and oxygen, is the safest and surest way for infant resuscitation, with no harm being done. . . .

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W. V. Chalmers-Francis, M. D. (1136 West Sixth Street, Los Angeles). — Doctor Wineland's very instructive paper covers the subject in a constructive manner, and emphasizes the value of physiology in medicine.

The need of a sound basic education for anyone who presumes to administer gaseous drugs to humans is appreciated by intelligent readers of such papers, and the author is to be congratulated.

The use of carbon dioxid in postoperative pulmonary conditions is becoming more routine than is advisable in hospital practice; there are too many cases where the surgeon, with but rudimentary preparation, orders its use at various hourly dosages. It is advisable to emphasize the danger of the use of carbon dioxid in shock: the Committee on Shock appointed by the Medical Research Committee warned us that, in shock, ventilation of the lungs with carbon dioxid does not improve the condition, and death may be produced by overventilation; there are better and safer treatments of this postoperative danger, such as blood transfusion and hypodermoclysis, to increase fluids and blood proteins; to ventilate the lungs after prolonged anesthesia is a proper treatment after surgery, best used on the operating table, and by the gravity method; the ventilation at this time aids elimination of ether and mucus and prevents pneumonic complications. When pneumonias occur, we have the authority of Bullowa, the clinical professor of medicine at New York University, in a worth while paper in *International Clinics* for December, 1931, as to value of oxygen therapy, in which he points out the best methods of administration, and he draws attention to the harm and distress in the concentrations of carbon dioxid over 3 and 6 per cent. It is advisable for the administration of carbon dioxid that it be given only under supervision of those who have devoted some real consideration to inhalation administrations, and not to be used as a routine order.

In newborn infants, resuscitation is often best accomplished with oxygen alone. Fetal anoxemia is produced by the control of labor pains through drugs and pressure on the cord during delivery. Opiates, N_2O with O_2, do diminish the oxygen content of the fetal blood, with N_2O inhalations during labor. During the relaxed uterine periods a good anesthetist will give high concentrations of oxygen to the mother, thus building up the oxygen content of the fetus so that pressure of the cord will not noticeably interfere with the O_2 supply to the fetus. When CO_2 is in excess of normal blood content, the respiration will become depressed, a condition due to extreme anoxemia; this lack of oxygen is not helped by CO_2 inhalations, but one good dose of oxygen will reëstablish respiration, and the pure O_2 supplied to the alveoli acts immediately, since the respiratory centers have been incapable of receiving stimuli because of this anoxemia.

One only emphasizes the warning as to the use of carbon dioxid to infants because we see in some hospitals the mistake of permitting the nurse to resuscitate the newborn infant while the obstetrician is busy with the mother. Too much stress cannot be made to limit

the practice of medicine, the prescribing of dosages of dangerous drugs, the diagnosing of the condition and cause of reactions, and the use of the right remedy for treating the condition arising, to the licensed practitioner.

℞

John Miller Wilson, M. D. (605 Professional Building, Pasadena).—Doctor Wineland's description of the therapeutic action of carbon dioxid explains why we get results when we use it. His explanation of the gravity method which he is using and recommending looks plausible and should be a very satisfactory way of administration to adults.

My use of carbon dioxid has been limited to pneumonias and other lung conditions, and in anesthesia, especially in lung and chest surgery by the tent or mask methods, using the 5 per cent carbon dioxid in oxygen mixture known as the so-called carbogen.

In cesarean operations the use of carbogen for a few breaths just before the incision into the uterus, and after the delivery before the cord is cut, makes it easy for the operator to deliver a pink baby, which should cry before it leaves the surgeon's hands.

As Doctor Wineland has stated, the dose of carbon dioxid should be small at first, and gradually increased as the need of the individual patient requires.

PRIMARY CARCINOMA OF THE URETER*

By Charles Pierre Mathé, M. D.

AND

Emilio De La Peña, M. D.

San Francisco

Discussion *by Paul A. Ferrier, M.D., Pasadena; J. C. Negley, M.D., Los Angeles.*

PRIMARY carcinoma of the ureter is a rare and obscure condition which offers difficulty in diagnosis. Its symptomatology is not always characteristic, and a goodly number of the reported cases were discovered either accidentally or at the autopsy table. Yet its early detection is a very worth while objective, as it offers the only chance for successful surgical relief, since these tumors have very early and widespread metastases. On account of its rarity, it is still well to report proved cases such as ours with the object of calling the profession's attention to its possibility, when an obstructive lesion of the ureter is encountered in a patient presenting the signs and symptoms of cancer, and in which stone formation and stricture can be reasonably ruled out. With this object in mind, we report a case diagnosed by modern urological methods, proved by operation and verified by autopsy. Recently the etiology, symptomatology, diagnosis, and treatment, including the end-results of primary carcinoma of the ureter, have been well covered by the numerous excellent monographs on the subject. Player [1] collected thirty-nine cases in 1928, Stampinato [2] eighty-nine cases in 1932, and Snyder and Wood [3] sixty-nine cases in 1933. Recently, in February, 1934, Scott [4] has reviewed the clinical course and results in forty-four cases treated by operation. A very complete review is that of Chauvin and Cerati,[5] who collected some 112 cases of malignant and benign primary tumors of the ureter reported up to 1932. The object of this paper is to add a proved case of primary carcinoma of the ureter to the literature, and to point out certain diagnostic points that will enhance its early detection, at which time the correct surgical treatment is most likely to give permanent relief.

REPORT OF CASE

Rev. J. B., Catholic priest, age 43, entered St. Mary's Hospital on June 12, 1933, having been referred from San Luis Obispo, because of left-sided renal colic, pain and swelling in the region of the left kidney and microscopic hematuria. For the past six years he had suffered several attacks of mild lumbar pain in the left lumbar region, radiating anteriorly to the lower abdominal quadrant and usually lasting a few days. Two months prior to his entry into the hospital, he experienced a severe attack of Dietl's crisis: sharp pain in the left lumbar region, which radiated anteriorly to the testis. The pain was so intense that an injection of an opiate was required before relief was obtained. The attack was accompanied by nausea and vomiting. There was no hematuria before, during or after the attack. Microscopical examination of the urine during this attack, however, revealed a large number of red-blood cells. Shortly afterward the patient became debilitated, the appetite poor, and he began to lose weight. He experienced no difficulty in urination.

Physical Examination.— General appearance, good. Heart and lungs, negative. Blood pressure: Systolic, 118; diastolic, 72. In the left upper abdominal quadrant a large, elongated, regular mass, corresponding to the left kidney, was palpated. It moved with respiration, and the overlying musculature in the upper abdominal quadrant and lumbar region presented some tenderness, but no rigidity.

Laboratory Examination.—Blood examination: Hemoglobin, 98 per cent; erythrocytes, 4,840,000; leukocytes, 12,050; polymorphonuclear leukocytes, 77 per cent; small mononuclear lymphocytes, 10 per cent; and large mononuclear lymphocytes, 13 per cent. Catheterized specimen of urine showed neither albumin nor sugar—a few mucous shreds, and an occasional leukocyte and erythrocyte. No neoplastic cells nor organisms were found. Phenolsulphonephthalein test: Seventy per cent recovered in two hours after intramuscular injection.

Cystoscopy, June 13, 1933, revealed no obstruction of the vesical outlet. There was injection of the trigone and bladder wall surrounding the left orifice. The ureteral spurt was absent on the left side. In passing the ureteral catheter up the left ureter, complete obstruction was encountered 11 centimeters from the orifice; and although the patient was placed in the extreme Trendelenburg position and various-shaped filiforms utilized, it was impossible to get by. A former attempt to pass by in San Luis Obispo had also been futile. Following the manipulations performed in an effort to pass by this obstruction, continual non-peristaltic bleeding came from the left orifice. Table 1 gives the kidney and bladder catheterized findings.

X-Ray Examination.— Roentgenological examination revealed a moderately enlarged left kidney, with no evidence of stone in either urinary tract. Retrograde pyelography revealed normal filling of the ureter to a point 11 centimeters from the left orifice. In this area a pressure defect was seen. Some of the iodid solution passed by an obstruction which had almost completely blocked the ureter at this point, filling the inferior calyx of the left kidney, which was found to

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Read before the Urology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

TABLE 1.—*Kidney and Bladder Findings*

	Kidney		Bladder
	Right	Left	
Microscopic	Turbid	No urine obtained Pure blood collected	Transvesical clear
Erythrocytes	Numerous		Few
Leukocytes	Occasional		Rare
Casts	None		None
Epithelium	Round and flat		Round and flat
Stained smear	Few gram negative bacilli		Few gram negative bacilli
Culture	Sterile		Sterile
Appearance time of indigo carmin	Three and one-half minutes	None in fifty minutes	
Grams of urea per litre	Four		Three

be considerably dilated. Intravenous urography was performed, and demonstrated immediate function of the right kidney with normal filling of the pelvis, calices and ureter. No excretion of dye appeared from the left kidney.

It was apparent that we were dealing with a pathological lesion almost completely obstructing the lower left ureter, which had caused considerable back pressure above, resulting in hydronephrosis and atrophy of the left kidney. Because of the bizarre pressure defect noted 11 centimeters above the left orifice, on account of the fact that we were unable to pass by an obstruction with various-shaped filiform bougies, and also because of the absence of stone, we assumed that the obstruction was either due to valvular hypertrophy of the ring muscle or to neoplasm of the ureter. As our investigations had clearly demonstrated that the left kidney had been destroyed by back pressure caused by this obstructive lesion, most probably a tumor, it was decided to perform a nephro-ureterectomy.

Operation. — Nephrectomy, June 27, 1933. Under nitrous oxid anesthesia, the usual curvo-linear incision was made on the left side. The kidney was found to be considerably enlarged and consisting of a hydronephrotic sac containing fluid under pressure. The pedicle was first ligated, after which the upper two-thirds of the ureter, including a constricting globular enlargement, was removed. Examination of a frozen section taken from the tumor at this time failed to reveal cancer cells, and we thought that we were dealing with constriction of the lower ureter due to a benign tumor, or to congenital or acquired hypertrophy of the annular smooth muscle fibers—a condition very much like that encountered at the uretero-pelvic juncture. A more detailed pathological examination made later revealed the tumor to be malignant, and containing mitotic figures. It was therefore decided to remove the remaining portion of the lower ureter, lest it should contain cancerous involvement. Two weeks later, July 11, 1933, the lower ureter was removed, through a retroperitoneal incision in the lower abdomen. Considerable peri-ureteritis was encountered, and the ureter was removed at the point where it entered the bladder wall: the intramural portion of the ureter was not removed. Careful examination of extirpated lower ureter revealed no evidence of cancer.

Surgical Specimen.—The specimen consists of an enlarged hydronephrotic left kidney, 9 by 4 by 6 centimeters, and ureter containing a spindle-shaped tumor measuring 2.5 centimeters by 8 millimeters situated 4.5 centimeters below the uretero-pelvic junction. On making frozen sections at the time of operation, the pathologist reported fibrosis and hypertrophy of the ring muscle of the ureter. However, sections made later revealed the true malignant nature of the tumor. The kidney is enlarged and discolored, the structures of the cortex presenting a grayish appearance. Sagittal incision of the kidney reveals considerable narrowing of the parenchyma which presents a pale, waxy appearance and dilatation of the pelvis, the walls of which are very much thickened.

Later sections of the tumor show marked fibrosis of the ureteral wall. The cicatricial tissue separates the muscle bundles, and it contains areas filled with atypical epithelial cells. These cells are directly contiguous with those forming the epithelial lining or mucosa of the ureter, and have a tendency to grow outward in masses infiltrating between the muscle layers, and extending nearly as far as the outer coat or serosa. The lumen is still patent, but is mechanically closed by invasion of tumor cells. A moderate number of mitotic figures are seen throughout the inner layers of the tumor. In the outer layers, the tumor cells do not appear to be as active and are compressed by muscular tissue.

Sections taken from the renal cortex show chronic interstitial nephritis and considerable thickening due to fibrous tissue. Throughout the cortex and medulla many areas of round-cell infiltration are seen. Many of the glomeruli are edematous. The convoluted tubules are dilated and the epithelial lining cells are flattened. These changes are apparently due to back pressure, resulting from obstruction of the ureter due to invasion by carcinoma. No tumor cells were found in any portion of the kidney.

Pathological Diagnosis. — Primary carcinoma of the ureter with occlusion of its lumen; hydronephrotic atrophy of the kidney.

Clinical Course.—Both the lumbar and the abdominal incisions rapidly healed, and the patient left the hospital on July 25, 1933, free of symptoms. He gained thirteen pounds in weight and felt rather well for about two months, at the end of which time he developed frequency, burning urination and mycturia. He reëntered the hospital on October 23, 1933, for reëxamination. Thirty per cent phenolsulphonephthalein was recovered in the urine in two hours after intramuscular injection. Cystoscopic examination revealed a contracted bladder with a capacity of 100 cubic centimeters. In the region of the left orifice, one could see a projecting nodular mass which seemed to push the bladder mucosa forward and which involved the posterior urethra. Rectal examination revealed a large, stony, hard mass above the prostate and the seminal vesicles which encroached upon the sigmoid. It was apparent that the neoplastic process had continued to develop and had involved the bladder wall. On November 14, the phthalein test had di-

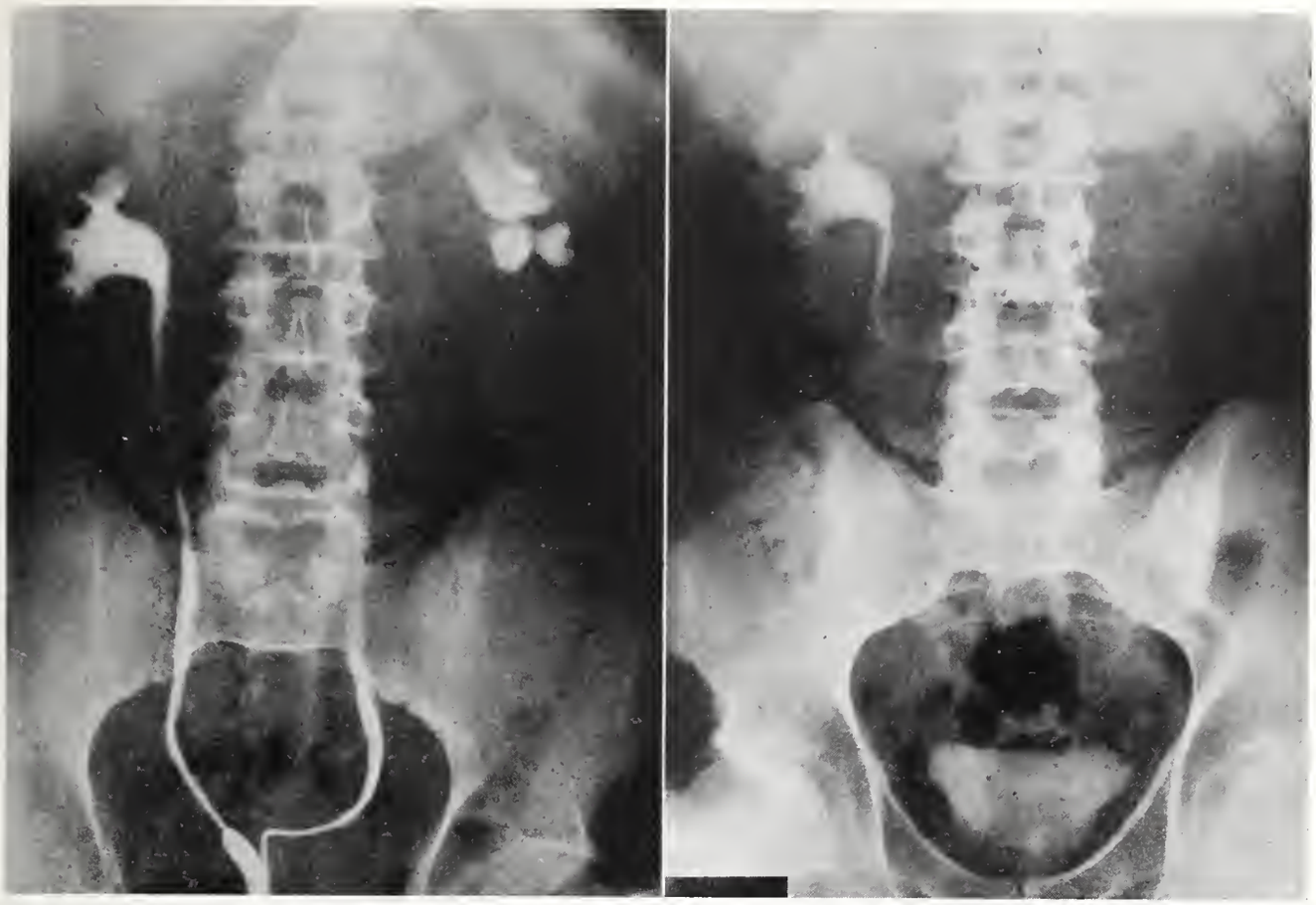


Fig. 1a

Fig. 1b

Fig. 1a.—Retrograde bilateral ureteropyelogram. Note normal filling of left ureter to a point 11 cubic centimeters from orifice at which catheter was obstructed and above which pressure defect is seen. Some of opaque solution has passed by obstructing ureteral carcinoma, filling middle calyx of left kidney, which is considerably dilated.

Fig. 1b.—Intravenous urogram demonstrating normal filling of right kidney pelvis, calices and ureter and no excretion of dye from left kidney.

minished to 5 per cent, and in attempting to perform intravenous pyelography, the right kidney failed to eliminate any of the injected dye. At this time the bladder was reëxamined by cystoscopy. The mass formerly noted in the region of the left ureteral orifice had greatly increased in size so that it now involved about half of the bladder projecting over and obscuring the right orifice. Blood chemistry was performed and the creatinin content was found to be 4.2 milligrams to 100 cubic centimeters. It was apparent that the tumor mass, in involving the bladder wall, had constricted the lower portion of the right ureter, causing back pressure and hydronephrosis. The creatinin content of the blood on November 18 was 4.2 milligrams; on December 2, 8.5 milligrams; on December 6, 8.5 milligrams; and on December 13, 6.5 milligrams to 100 cubic centimeters. Colostomy was proposed to relieve progression bowel obstruction, and ureterostomy into the groin was also suggested as a palliative measure in order to establish urinary drainage and to prevent impending uremia. The patient refused these palliative measures, including radium therapy, gradually lost strength and weight, and died in uremic coma on January 14, 1934.

Necropsy.—January 14, 1934. The patient is greatly emaciated. The abdomen is distended. There are a large number of petechiae over the abdomen and thighs. There is a scar in the left lower abdomen, resulting from a former ureterectomy, and also a nephrectomy scar in the left lumbar region. The peritoneum is filled with clear amber colored fluid. The peritoneum is smooth and the omentum is folded over the stomach. The pelvic cavity is frozen solid with an extensive invading tumor mass. This neoplasm has encroached on the descending colon, which is filled with fecal matter. The ascending colon and the appendix are drawn up into the right upper abdominal quadrant to a position under the liver and gall-bladder. The liver contains numerous hard fibrous neoplastic nodules. There are small miliary nodules in the omentum, mesentery and spleen. The bladder wall is entirely invaded with a neoplastic growth and measures 1.5 centimeter in thickness. The right ureter enters the bladder in the midline, and in attempting to catheterize this tube with a bougie from above downward, an obstruction was encountered in the intramural portion where it traverses the bladder wall. The ureter was then dissected free, as far as the kidney; after which this organ was liberated and removed. The ureter and kidney pelves were considerably dilated and presented a very thin wall. The ureter was constricted at the point where it passed over the pelvic promontory. This constriction of the ureter was due to a tumor mass which had surrounded it and partially closed it off by external pressure. A similar constriction of the intramural portion of the ureter was found to be due to involvement of the bladder wall.

Diagnosis.—Primary carcinoma of the ureter with metastasis into the bladder, liver, omentum and spleen. Hydronephrosis and hydroureter, right.

Microscopic Pathology.—Sections through the bladder wall reveal constriction of the musculature, which is due to the development of fibrous tissue. Between the bundles of muscles one notes extensive infiltration, with groups of small round epithelial cells in almost every portion. These cells are found to be in every portion of the bladder wall extending from the peritoneum to the mucosa. They occupy the small endothelial lined spaces made up of veins and lymph capillaries. Under the peritoneum there are large masses of these cells, some of which have coalesced and invaded the retroperitoneal fat, forming quite an extensive tumor.

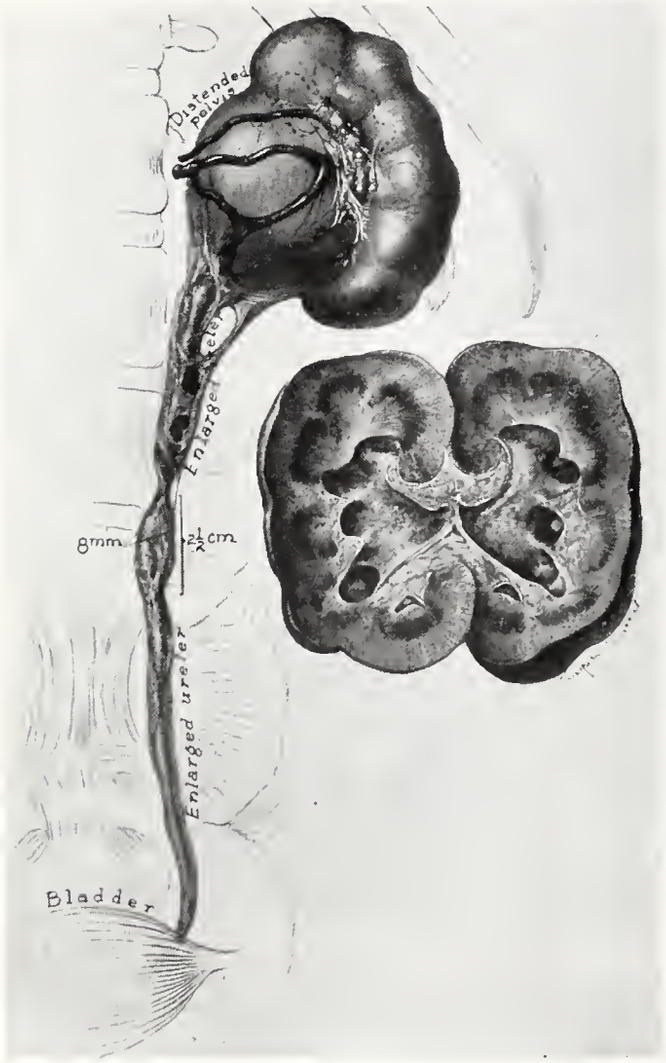


Fig. 2.—Illustration showing carcinoma of ureter and enlarged hydronephrotic kidney above. The extirpated organ presents dilatation of pelvis and narrowing of parenchyma in which there was found advanced cicatricial changes due to nephritis. Kidney and lower ureter not involved by carcinoma.

Section of the liver shows even greater permeability to these tumor cells. There are large masses of infiltrating cells, which have broken through the smallest capillaries. The tumor mass seems to follow the vessels just under the liver capsule, and contains numerous mitotic figures. As many as eighteen or nineteen mitotic figures can be seen in one high dry power field. In the region of the tumor, the liver cells themselves present very marked granular brown atrophy.

Section of the kidney reveals dilatation of the conducting tubules and a moderate amount of cicatricial tissue involving the blood vessels and glomeruli. There are a few areas which show round-cell infiltration, and these are more marked in the region of the cortex. A number of the glomeruli and convoluted tubules present marked edema. Few of the tubules show casts. No tumor cells are observed in the sections obtained from the kidney.

Final Diagnosis.—Primary carcinoma of ureter for which operation was performed; with metastases in the bladder, peritoneum, mesentery, and liver. Hydronephrotic atrophy of opposite kidney (right) due to partial obstruction of lower ureter.

SYMPTOMATOLOGY

The symptoms due to carcinoma of the ureter simulate those of other obstructive lesions of the ureter or neoplasms of the kidney. Although its diagnosis is obscure, certain symptoms should lead one to suspect the possibility of this condition. These are hematuria, pain and tumefaction of the kidney, accompanied by the general symptoms of cancer, consisting of loss of weight, anorexia, debility, and cachexia. Hematuria is a symptom of tumor of the prostate gland, bladder, ureter, or kidney. Cystoscopic examination of the bladder will soon rule out tumor of this viscus, and that of the prostate gland and ureteral catheterization will demonstrate if the blood is coming from a certain portion of this tube rather than from the kidney above. Hematuria may be abundant, spontaneous or intermittent, and is often accompanied by the emission of clots. In certain cases, like in our own, hematuria is very slight and can only be determined by making a microscopical examination of the urine. The formation of a tumor in the ureter, which consists of a narrow tube, rapidly forms an obstruction to the outflow of urine, causing back pressure, which soon results in hydroureter and hydronephrosis. This leads to tumefaction of the kidney, which is detectable by palpation or by roentgenological examination of this organ. The obstructing tumor soon gives rise to pain, which occurs as intermittent attacks of renal crisis, or is of the dull lumbar or upper abdominal type. A number of accessory symptoms such as frequency, urgency, pain in the bladder, etc., sometimes occur. When the triad of symptoms, consisting of hematuria, pain, and tumefaction of the kidney, occur, accompanied by loss of weight, debility and cachexia, one should bear cancer of the ureter in mind as well as renal tumor.



Fig. 3.—Microphotograph of transverse section through involved ureter showing carcinomatous infiltration of ureteral wall with extension into its lumen, producing almost complete mechanical obstruction.

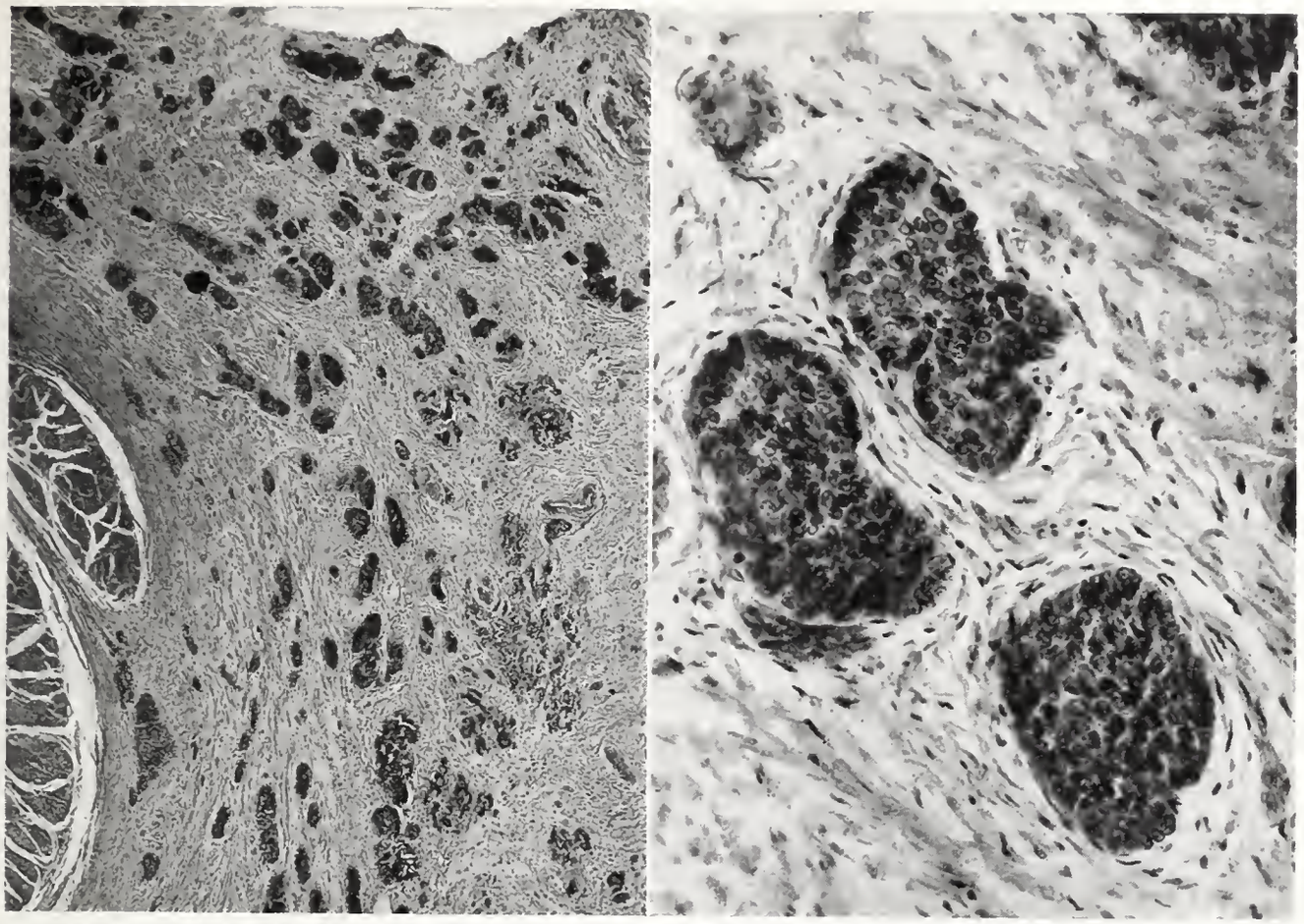


Fig. 4a

Fig. 4b

Fig. 4a.—Microphotograph of bladder wall involved by metastasis, showing fibrosis and invasion by groups of cells between muscle bundles.

Fig. 4b.—Microscopical appearance of these groups of actively growing epithelial cells containing mitotic figures. Similar cells were found in the original tumor, and other metastasis in the peritoneum, mesentery and liver.

DIAGNOSIS

The diagnosis of carcinoma of the ureter is obscure, yet certain positive signs will aid one to detect this rare condition. In making a cystoscopic study of the affected side from which bleeding is observed, one is often unable to pass the catheter beyond the obstructing tumor. Repeated attempts are often unsuccessful. In moving and twisting the catheter in order to attempt to pass by, non-peristaltic free bleeding results. This is detected by observing the ureteral orifice, and is different from that caused in patients presenting stone and stricture formation of the ureter in which bleeding, when produced, is usually peristaltic in nature. If one is able to pass by the obstructing tumor, this bleeding ceases and clear urine may be obtained. Differentiation of ureteral tumor from the non-opaque uric acid calculus is quite difficult. The recovery of uric acid crystals from the urine of the involved ureter is of great assistance, and is pathognomonic of uric acid calculus. In some cases the tumor cells can be recovered from the urine. One should also suspect ureteral tumor in cases in which hematuria is found to come from a ureter that has been left behind after nephrectomy for hydronephrosis. Such a case was recently reported by Davis and Sachs.[6] Another was observed by my associate, Dr. George Oviedo, in which the hydronephrotic kidney, however, also contained cancerous involvement. Cystoscopy sometimes shows projection of the tumor from the ureteral orifice or an implantation tumor in the mucosa close by. Careful observation of the orifice will show modification of the ureteral spurt, and the orifice itself is in some cases dilated. In patients presenting tumor of the lower ureter, it can sometimes be palpated by way of the vagina or rectum. Urography is of great aid. When one is able to pass the catheter by the obstructing tumor, a filling defect in the lumen of this tube is encountered, above which the ureter and kidney pelvis is dilated. In some, the ureter has a moth-eaten appearance, very much like that produced by tuberculosis. In those patients in whom one is unable to pass the catheter by the obstructing tumor, intravenous urography will demonstrate the filling defect and hydronephrosis. Unfortunately, as in our own case, renal function is reduced to such a degree that the dye is not secreted by the weakened organ, and no outline of the ureter or kidney is securable. In a suspected case of carcinoma of the ureter, the salient physical signs are: the presence of a tumor growth projecting from the ureteral orifice or in the adjacent mucosa, an impassable obstruction in the ureter, modification of the ureteral spurt, non-peristaltic hematuria resulting from attempts to pass by with a catheter, and a urographic filling defect of the

ureter with hydroureter and hydronephrosis above the point of pressure.

TREATMENT

Although in a very few selected cases of primary carcinoma of the lower-most portion of the ureter it might be possible to remove the involved ureter transvesically and perform ureterocystoneostomy, complete nephro-ureterectomy in one sitting, including removal of the intramural portion of the ureter, is the most rational procedure and has given the best results. Crance and Knickerbocker [7] report an eight-year cure, and Kraft an eleven-year cure by this complete operation. Partial resection of the ureter, including the tumor, accompanied by ureterostomy, had been performed mostly on advanced cases, and these patients later died from metastasis. Nephrectomy followed by ureterectomy is a common procedure. We utilized this method in our own case because, at the time of the first intervention, a frozen section of the tumor failed to reveal malignancy, and ureterectomy was performed at a later date in order to assure removal of cancerous involvement that might have been present in the lower ureter. Had we known that we were dealing with a malignant growth, complete nephro-ureterectomy in one sitting would have been performed. In performing nephro-ureterectomy, the kidney is removed through the usual lumbar incision, and the lower ureter through the customary retroperitoneal incision of the lower abdomen after the method of Gutierrez.[8] Complete nephro-ureterectomy in one sitting should be the treatment of choice, as the entire upper urinary tract is removed on one side, assuring eradication of any cancerous cells that might have been implanted lower down in the mucosa of the ureter. In cases in which the diagnosis of carcinoma of the ureter is strongly suspected, but cannot be definitely proved, exploratory operation is justified.

COMMENT

In our case of primary carcinoma of the ureter, neoplastic involvement was diagnosed prior to surgical intervention. Frozen sections made at the time of operation failed to demonstrate malignant properties, and we then thought that we were dealing with annular hypertrophy of the ring muscle of the ureter or a benign tumor. For this reason, at the time of the nephrectomy, we were content to remove the upper ureter containing the tumor and the kidney destroyed by hydronephrosis. When, on further study, the malignant nature of the tumor had been established, the lower ureter was removed later and the patient died from metastasis. It is probable that the blood stream and lymph channels had already been invaded by cancerous cells at the time of the first intervention, as an extensive fibrous reaction was noted to exist in the tissues surrounding the tumor, and also in those surrounding the lower ureter. It is possible that, at this time, metastasis had not taken place, and recurrence was due to the growth of implantation cells in the intramural portion of the ureter which had not been removed. In retrospection of this case, the following deductions can be made:

1. Early diagnosis of primary carcinoma of the ureter is a well worthwhile objective, as it offers the only chance of cure by early surgical removal.

2. One should bear in mind the possibility of primary cancer of the ureter in patients presenting the general symptoms of cancer, and who present the triad of symptoms, consisting of hematuria, lumbar pain and tumefaction of the kidney, in whom ureteral obstruction is encountered, and in whom one can reasonably rule out stone, ureteral stricture and tumor of the kidney.

3. Salient points in establishing a positive diagnosis are: the presence of a tumor growth projecting from the ureteral orifice or in the adjacent mucosa, an impassable obstruction in the ureter, modification of the ureteral spurt, non-peristaltic hematuria resulting from attempts to pass by with a catheter, and a filling urographic defect of the ureter, with hydroureter and hydronephrosis above the point of pressure.

4. The treatment of choice that is most likely to give lasting results is complete nephro-ureterectomy, when feasible, including removal of the intramural portion of the ureter in one sitting.

We wish to express our thanks to Dr. Elmer Smith, pathologist of St. Mary's Hospital, for the pathological studies carried out in this case.

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DISCUSSION

Paul A. Ferrier, M.D. (65 North Madison Avenue, Pasadena).—We are indebted to Doctor Mathé for this detailed report of a condition very difficult to diagnose. As happens sometimes in relatively rare conditions, such carcinomas come in groups. Dr. A. G. Foord, pathologist of the Pasadena Hospital, has had three of these at autopsy during the past year. The patients had not been in the hands of urologists and they had been said to have ovarian tumors. Two were squamous and one was papillary. In the latter

* Contains important recent references and cases reported in 1932, 1933 and 1934. For former references consult articles by Snyder and Wood and by Chauvin and Cerati.

case the kidney was gone over very thoroughly, and no evidence of papillary growth was found in the kidney itself.

During the same year I had a case personally of primary carcinoma of the ureter, in which the diagnostic findings were not very unlike Doctor Mathé's, except that it was not possible to force any opaque fluid past the growth. On intravenous injection of neo-iopax, no dye whatever was secreted by the blocked kidney. An unusual feature was that bleeding continued long after the ureteral block was complete, and this came from ulcerated varicosities in the submucosal veins of the ureter for a distance of about seven centimeters below the tumor. X-rays of the pelvis and chest were negative. The diagnosis of ureteral tumor was made in this case, and the kidney and entire ureter were removed at one time. The tumor had adhered to the common iliac vessels. No para-aortic glands were palpable.

Pathological examination showed a ring tumor completely occluding the ureter at the brim of the pelvis, well away from the bladder. The kidney was hydronephrotic and atrophied. It had no tumor. The microscopic diagnosis was that of Doctor Mathé's case, namely, squamous-celled carcinoma primary in the ureter.

The patient is in good condition seven months after operation.

❦

J. C. Negley, M.D. (527 West Seventh Street, Los Angeles).—Doctor Mathé's presentation of this rather unusual case demonstrates advances made in, and the exactness of diagnostic urology.

In the past six years the patient has had several attacks of left lumbar pains which radiated to anterior left lower abdomen, lasting a few days. Probably the original lesion began then with subsequent stricture of ureter from calculus, inflammatory process localized in ureter or surrounding tissues, with subsequent malignant growth in this area, as malignancy forms on gastric ulcer, rectal lesions, etc.

Malignancy was early and preceded by a long period by other pathology as evidenced by the facts that (*a*) a frozen section failed to demonstrate malignancy, and (*b*) the predominating findings in surgical specimens, frozen sections, regular sections were fibrosis, hypertrophy and scar tissue. If the patient had been cystoscoped and carefully studied any time between his initial attack and the first disabling attack, ordinary cystoscopic treatment might have saved the kidney, or early nephro-ureterectomy would surely have prevented the malignancy.

Autopsy findings and early signs of metastasis indicate that at operation lymph channels had indiscernible invasion (evidenced by extension down descending colon to left side of bladder, the entire bladder and pelvis). Liver involvement indicates a blood invasion, either then or later.

I am in entire accord with all points made by the author, and would emphasize the following:

1. Diagnosis of primary malignancy of the ureter is possible in the majority of cases.

2. Intravenous urography is sadly lacking in exactness of diagnosis, as compared with retrograde urography.

3. Frozen sections, even those made by the most competent pathologists, are often misleading and of undeniable value only when positive.

4. Exactness of diagnosis in urology is unexcelled by any other branch of medicine. However, laity and the profession at large do not always make early or good use of available diagnostic procedures.

5. Doctor Mathé is to be commended for his excellent care of this patient, and surely deserved a more fortunate end-result.

SPINAL CORD INJURIES—THEIR TREATMENT*

By Howard W. Fleming, M. D.
San Francisco

Discussion *by Frederick Leet Reichert, M.D., San Francisco; Edmund J. Morrissey, M.D., San Francisco; Mark Albert Glaser, M.D., Los Angeles.*

ONE of the most difficult problems confronting the surgeon is the care of injuries of the spinal cord. Nor is agreement as to management and treatment to be found in the literature. In view of this situation, a consideration of some of the fundamental facts in relation to trauma of the cord may be of value.

EMERGENCY CARE OF SPINAL-CORD INJURIES

The emergency care of patients with injuries to the spinal cord is extremely important. Neglect, delay or improper treatment will often give rise to complications that materially influence the prognosis as to recovery, the comfort of the patient, and the difficulties and cost of subsequent care.

The original examination and transportation of the patient require care. Rough or careless handling may alter the damage to the cord from a minor to a major contusion. The patient should be placed on an air mattress as soon as possible, for undue pressure on an anesthetic area may devitalize tissue within a few hours. The resultant pressure sore will require months of careful nursing.

SHOCK

It is necessary only to mention that serious shock, if present, is our first consideration. Elaborate methods of diagnosis and treatment must be delayed until the patient's condition warrants their use. Occasionally, associated intra-abdominal injuries, or those of the chest, are not recognized in the presence of serious damage to the spinal cord. More frequently, severe injury to the cord is not appreciated if the patient has an associated injury of the head. The combination of injury to the head and cervical cord is fairly frequent, and must be borne in mind.

CARE OF THE BLADDER

Care of the bladder is an important consideration. There is usually a retention of urine, and all too often the patient is catheterized early. Infection results, and frequent or continuous drainage becomes necessary. Urinary infection is a common cause of death in patients with paraplegia. Often catheterization can be avoided entirely by allowing the bladder to overflow. Several of our patients never have been catheterized, and have had no complications arising from urinary infection. The bladder may reach an alarming size, and it is difficult to resist the urgent demands of the patient, intern, and nurse to empty it. Usu-

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Read before the General Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

ally within forty-eight hours, gentle pressure will be effective, and there is little difficulty after overflow begins. Many urologists do not subscribe to such treatment, but, in my experience, the patients who never have been catheterized are spared many or all of the usual urinary complications. This plan is more debatable in patients in whom there is a reasonable certainty that control of the bladder may be restored.

CAREFUL EXAMINATION AND DIAGNOSIS IMPORTANT

Careful examination, as early as the patient's condition warrants, is essential for several reasons. It is important to determine the pathologic change and dysfunction resulting from the injury alone. Increasing signs of dysfunction, or new symptoms superimposed, suggest further hemorrhage, edema, or pressure requiring surgical intervention. Experimental evidence and clinical observation have shown that edema following contusion of the cord is rapid, and that it may reach its peak within a period of from eight to twelve hours. Because of hemorrhage and edema, the cord swells until it completely fills the dural sac. The tension from within and without renders the cord ischemic. This deprivation of circulation destroys the remaining undamaged tissue within the cord and converts a partial destruction of the cord into a complete one. Such an occurrence must be anticipated and prevented.

ROENTGEN-RAY EXAMINATION

Roentgen-ray studies are an important part of the examination. Lateral views, particularly, may show dislocation of a type compatible only with a complete shearing off of all structures in the canal. Partial dislocation, even in the absence of signs of injury to the cord, requires treatment to prevent late sequelae. Occasionally, depressed laminae projecting into the spinal canal indicate the necessity for laminectomy.

SPINAL PUNCTURE

Spinal puncture is one of our most valuable diagnostic aids. It is a simple procedure to introduce a needle into the lumbar space and attach a manometer. It requires far less movement of the patient than the taking of x-ray films, and usually gives greater information as to the presence of pressure on the cord. If jugular compression indicates no block of the spinal canal, it is a fair assumption that operation and decompression are not indicated. On the other hand, if there is a block of the canal, the advisability of operation must be considered.

COMPLETE AND PARTIAL SEVERANCE OF THE CORD

Complete severance of the cord is beyond relief. Partial anatomical lesions, however, frequently give the picture of a total physiological loss. It is not possible to diagnose a complete severance of the cord from the neurological findings alone. We feel that it is reasonable to use the evidence of continuing compression on the cord, as obtained by the manometric interpretation, as one indication for laminectomy. No doubt many patients will be operated on unnecessarily if this rule is followed; on the other hand, some few will be helped materially.

SURGICAL PROCEDURES AND HAZARDS

The question may be raised as to what may be accomplished by surgery, and also as to the dangers incidental to operation. Local anesthesia is usually sufficient and adds little hazard for a patient in fair condition. Great care must be used in exposing the cord, for undue roughness may cause further injury. The exposure of fragments of bone pressing on or through the dura indicates that the operation has been warranted. Extradural hematomata occasionally are found and can be evacuated. In the great majority of cases the dura should be opened to allow inspection of the cord. Frequently the cord fills the canal, and it is necessary to expose the dura well above and below the point of major injury. Often the cord appears normal even at the level at which severe intramedullary damage has occurred. If the cord is badly swollen, and the clinical picture is one of great physiological loss, exploration of the cord itself is in order. A small knife or round needle introduced to either side of the dorsal sulcus will allow evacuation of old blood or broken-down nervous tissue. Frequently the broken-down elements of the cord have the appearance of oil, and pour out under increased pressure. Following such a procedure, the decreased size of the cord, and the return of pulsation, suggest an improved circulation. It may be advisable to leave the dura open if there is any question as to continuance or further increase of pressure.

The greater majority of injuries to the cord are in the low cervical and dorsolumbar regions. The mobility of the spine in these parts, contrasted with the fixation of the thoracic spine, is conducive to dislocation or a combination of fracture and dislocation. Frequently, manipulation with reduction of the dislocation is all that is necessary.

DISLOCATIONS OF CERVICAL VERTEBRAE

In the treatment of dislocations of cervical vertebrae, it has been our practice to use a procedure that, as far as I know, has not been described previously. While it is necessary to reduce the deformity of the spine, it is far more important that the cervical cord be relieved of pressure. Several methods have been described for the reduction of the dislocation. We have found the technique described by Taylor to be the most satisfactory. A halter is placed on the patient's head and fitted as carefully as possible to reduce pain and discomfort to a minimum. The straps of the halter are attached firmly to a belt worn by the operator. This arrangement allows the surgeon the use of his hands in the manipulation of the head and neck; and at the same time he is able to exert a steady and controlled force in extension. Countertraction is best applied to the lower extremities by assistants. It is usually necessary to flex the spine gently before the articular facets can be unlocked. This is followed by further and

stronger traction with gradual extension; and often the reduction can be felt or even heard. If x-ray equipment is available, lateral films may be taken and usually confirm a satisfactory reduction.

It has been our practice to supplement this technique in the following manner: the patient is placed on his side or, in a few instances, in a sitting position, with traction applied from above. A spinal needle is introduced into the lumbar space and a manometer is attached. Jugular compression will indicate the presence of a partial or complete block of the canal. If no block is present prior to manipulation, but occurs during or following the procedure, it is a clear indication that the cord is being compressed and constitutes an outstanding danger signal. On the other hand, if evidence of intraspinal block is corrected by manipulation, one is confident that pressure on the cord has been relieved and, very probably, a satisfactory reduction of the dislocation has been accomplished.

INTRASPINAL BLOCK

We have found that, in some cases, although x-ray films indicate a satisfactory reduction, signs of intraspinal block persist. Occasionally, a slight change in the position of the head and neck will open the canal, and one is able to determine, by means of the manometer, the position that will insure the maximum relief of pressure on the cord. If block is present prior to, and is not relieved by the usual manipulation, one concludes that the cord is so swollen as to occlude the canal. Naturally, this condition increases the hazard of manipulation greatly and open reduction should be considered.

In such cases traction can be applied to the head by means of calipers fastened into the mastoid processes. The laminectomy is carefully done, exposing the cord above and below the point of injury. With the cord in view, heavy traction and manipulation can be made with less hazard of injury to the cord. Often the deformity interfering with the reduction is readily apparent, and can be corrected by the open method.

We feel that the use of the Queckenstedt test as an adjunct during the manipulation of cervical dislocations has many advantages. Its use will indicate the relief, the continuation, or the imposition of pressure on the cord as the result of a necessary but fairly hazardous procedure. In the final analysis, the condition of the cord is our chief concern, and deformity of the vertebrae is of secondary consideration. I do not mean to imply that we should not make every effort to prevent and correct deformity of bone, but I do feel that, frequently, treatment is directed along improper lines. Too often a patient with an injury to his back is subjected to an operation to immobilize the spine, without consideration as to investigation and treatment of injuries to the cord and nerves.

If deformity of the spine persists or recurs in spite of therapy, the cord may be subjected to continued or additional pressure. Intraspinal block, or the delayed sequelae of complications suggestive of involvement of the cord, indicates the necessity for operation. In neglected cases it is usually impossible to correct the deformity of bone causing pressure on the anterior surface of the cord. Removal of laminae may afford some relief of pressure. Much of the traction of the dura and cord caused by angulation may be relieved by cutting the dura laterally and transversely, above and below the point of stricture. If this is not done, the dura, which is most inelastic, acts as a bowstring and increases tension on the cord.

INJURIES OF THE CAUDA EQUINA

Special consideration must be given to injuries of the cauda equina. Here one is dealing with nerve tissue somewhat analogous to peripheral nerves. Regeneration is possible, and every effort should be made to facilitate repair. Frequently the injury is in the region of the first lumbar or twelfth thoracic vertebra. Even though the conus is irreparably injured by extensive dislocation, lesions of the roots and cauda equina are amenable to treatment. If the patient regains flexion of the thighs, his ability to get about in a chair is greatly improved.

Hyperextension often will reduce the dislocation. In these cases the use of the Queckenstedt test is also of value. If hyperextension does not relieve the block, laminectomy is in order. Painstaking hemostasis, careful removal of clots and separation of the roots may prevent the organization of blood and nerve elements into a dense mass of scar tissue with resultant compression of the elements of the cauda equina. Laminectomy in injuries of the cauda equina is somewhat comparable to the neurolysis of peripheral nerves.

A PLAN OF PROCEDURE IS DESIRABLE

It is probably true that, in cases in which the cord has been very slightly or, in contrast, very seriously contused, the type of treatment used will not alter the prognosis materially. In the borderline cases, therapy often will determine the extent of permanent disability. Recourse to the textbooks and literature indicates great confusion on this subject, and disagreement as to treatment. It is necessary, at least, to have some plan in mind when faced with the problem of caring for injuries of the spinal cord. Adherence to the foregoing suggestions has been helpful in providing such a plan—one in which I have learned to place confidence.

TO SUMMARIZE

For the sake of emphasis, I conclude with the following summary:

1. The emergency treatment of injuries to the spinal cord is extremely important. Great care must be used to prevent further injury. Shock must be recognized and treated promptly. The possibility of coincidental or complicating injuries must be borne in mind.

2. The patient should be placed on an air mattress at once. Delay of a few hours only in this detail usually means many months of unnecessary care of a pressure sore.

3. The great majority of patients should not be catheterized. A urinary tract once infected is a constant menace to both the well-being and the life of the patient.

4. New and increasing signs of damage to the cord indicate the necessity for active treatment. X-ray evidence of bone or foreign body pressing on the cord suggests the advisability of operation.

5. Compression of the spinal cord impairs the venous and arterial circulation. This, in turn, retards repair, and may further jeopardize fibers and cells of the cord that are still viable.

6. The Queckenstedt test is our best means of determining whether the cord is compressed, and a positive test is one indication for manipulation or operation.

7. The use of the Queckenstedt test at the time of manipulation or reduction of a dislocation of cervical vertebrae is extremely helpful.

384 Post Street.

DISCUSSION

FREDERICK LEET REICHERT, M.D. (Stanford Hospital, San Francisco).—Doctor Fleming's article on the injuries of the spinal cord and their treatment emphasizes the importance of careful examination and an early diagnosis. The use of the Queckenstedt test, as an aid in determining whether a severe injury to the cord has led to a complete block, and particularly the use of this test after the reduction of dislocated cervical vertebrae is an excellent adjunct in deciding whether operative interference is indicated.

One cannot emphasize too strongly the fact that once paraplegia has developed, following a spinal cord injury, pressure sores will occur within just a few hours.

The use of hot-water bottles to overcome shock seems to do more harm than good in such cases, since the burns that develop become major factors in treatment, and the treatment of shock by other means would have led to less disastrous results.

EDMUND J. MORRISSEY, M.D. (234 Medical Building, San Francisco).—The plan outlined by Doctor Fleming for the treatment of spinal cord injuries is excellent. It emphasizes the importance of nursing care and the proper treatment of the bladder, and is neither too radical nor too conservative.

There is no subject in the field of neurological surgery in which there is such a wide divergence of opinion. This will continue because we are unable to distinguish, in the first few weeks, between an anatomical and a physiological interruption; and when improvement does follow surgery it is impossible, as a rule, to say with any degree of certainty that such betterment is the direct result of the operative intervention.

There is no doubt that in the great majority of cases the damage takes place immediately as a result of direct injury and, therefore, the results of surgery are disappointing. The conditions which might justify operation are, first, a block as demonstrated by the Queckenstedt sign, which is not relieved by reduction of the dislocation; second, impingement into the canal of fragments of bone as demonstrated by x-ray; and third, increasing neurological findings.

Operation offers more hope when the lesion involves the cauda equina. In one case I found the dura torn and one of the edges with two posterior roots caught in between the fracture of the lamina.

MARK ALBERT GLASER, M. D. (727 West Seventh Street, Los Angeles).—Doctor Fleming has carefully emphasized the importance of the jugular compression test, and has added a very valuable addition to be used in cervical and cauda equina injuries. These new points that Doctor Fleming brought up are extremely ingenious, and one cannot compliment him sufficiently for such keen observations.

Spinal concussion is quite possible, and may be compared with cerebral concussion. The results of spinal concussion with edema and pin-point hemorrhage would be a complete paraplegia. Personally, I have had the opportunity of seeing several cases wherein the bullet wound grazed the vertebral column, but did not cause a dislocation. A few of the particles of lead were visible along the body of the vertebra where the bullet had touched. The result was a complete paraplegia. The jugular compression response was normal, and there was no blood upon spinal puncture. From this we may assume a cord edema with pin-point hemorrhage.

In view of the dehydrating effects of glucose and other solutions in cases of head injury, we thought it advisable to carry out such therapeutic measures with the hope that some good could be accomplished.

Spinal injury also simulates skull injury in that the damage to the underlying nervous tissue is not always related to the bony destruction. Furthermore, sequelae arising secondary to spinal injuries which are not based upon any organic pathology are extremely incapacitating. The severity of the injury has no relationship to the development of the various types of backache that may occur.

Additional measures must be directed to the treatment of such signs, and efforts made to combat the existing neurosis. Often it is impossible without a *sub rosa* investigation to clinically differentiate the malingerer from the psychoneurotic.

MALARIAL TREATMENT OF GENERAL PARESIS*

By F. J. VAN METER, M. D.
Norwalk

DISCUSSION *by Clifford W. Mack, M.D., Livermore; Samuel D. Ingham, M.D., Los Angeles; G. Creswell Burns, M.D., Compton.*

MALARIAL treatment of neurosyphilis has long ago passed the stage of experiment and doubt, and has established itself as a standard remedial measure, as a result of the encouraging reports concerning its use from all over the country. No disease, perhaps, has presented such an utterly hopeless outlook as general paresis until the advent of the arsenicals; and even then, with that advantageous treatment, the results were not all that could be desired. However, admittedly there was a general improvement in a certain group of those who received the drug treatment.

Now, inoculation with malaria has gradually brought an increase in the number of improved patients beyond that seen as a result of treatment with arsenicals, and is, therefore, due to receive such credit as it may. This is borne out by the experiences of many men everywhere, and the literature is replete with improved percentages, all the way from 15 to 35 per cent—something unknown and scarcely hoped for in the years gone by.

CLINICAL MATERIAL STUDIED

In December of 1926, a small group of seven patients in the Norwalk State Hospital were in-

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

oculated with tertian malaria. The results were not encouraging at that time; on the whole, however, one of this group of men is still living, moderately improved, but not well enough to leave the hospital. The others have passed away at varying lengths of time, but not as a result of the treatment. We found these patients were too far advanced in paresis, and too much impaired physically to be good subjects for the treatment. It may be said that, subsequently, more care was used in selection of subjects, and a year later a more stabilized improvement was noted.

In a group of forty-nine patients treated a year after the inception of the use of malaria, about 12 per cent exhibited an encouraging improvement in that there was a disappearance of mental symptoms, such as delusions, irritableness, combativeness, and the like. The serology, however, exhibited little change, and it was estimated at that time, and statements so made, that the treatment probably was not going to affect the serology. Depressed paretics were believed to respond better to the treatment.

Negro patients were found largely immune, and that is still our viewpoint, following the treatment of as large a group as six hundred. This is comparable to the experiences of others with the negro race. Likewise, Filipinos do not respond to the inoculation many times. While it is possible in some instances to learn that the patient has had a previous attack of malaria, and likely has an immunity, in others there is no history of a previous attack.

In the latter part of 1928, a group of 148 patients had been treated, and on investigating the condition of these patients it was discovered that the Wassermann still remained unchanged largely, after a period even of two years, but the cell count in the spinal fluid was reduced, sometimes to normal, and the globulin was negative. It will be noted here that it was first assumed that there was no change to be expected in the serology, based on our earlier experience, and on the smaller group. General improved condition among this larger group of patients, with apparent remissions, were more frequent, and 15 per cent showed a more durable and lasting improved state. It was felt, as a result of two years' experience, that opinions relative to the efficacy of the treatment should be deferred until six months to a year, or more, after the treatment had been completed.

COMMENT

It is true that, clinically, the patients sometimes improved within a few weeks; but the patient and his relatives, and of course the physician, are particularly interested in the serology, and many times judged the treatment according to what effect it had on the Wassermann. While it naturally is a desirable result to attain lessened positivity, the patient may reach a considerable degree of improvement clinically, and his Wassermann remain unchanged, or at least altered little. We are not treating the Wassermann, we are treating the patient. Some of those patients who after prolonged treatment have exhibited a negative Wassermann on the spinal fluid are steadily deteriorating, while others are improved who remain positive. The fond relatives expected that some miraculous change would come about immediately the treatment had been given.

The public prints wrote up the treatment as a cure for insanity, which it was not, and is not. We should be guarded in giving opinions concerning what malaria will do, and consider the form of neurosyphilis and its degfee of advancement before giving a prognosis.

LATER RESULTS

In December of 1929, two hundred and thirty-four patients in all had been treated as described, with the result that we found 25 per cent of them, approximately, markedly improved, or in temporary remissions, and of these, about 14 per cent were able to leave the hospital, but on parole; none were deemed recovered, and there is no information submitted to the institution that they have entirely recovered their former mental health. However, there is no question of their genuinely improved state. The unimproved group of the 234 patients totaled 15 per cent. Now, in this unimproved group little results were shown: the patients had no change in the serology, continued to deteriorate mentally, were deluded, irritable, combative, and showed the general progressive debilitation of paresis. Among the improved there was noted still a positivity of the Wassermann, but a negative globulin, and a cell count normal, or nearly so. Two patients of the 234, on the other hand, showed a slight reduction in the spinal fluid Wassermann, which elicited the hope that later on there might be some alteration.

A group of four hundred patients had been treated by November of 1931, and the markedly improved and stabilized patients in this group amounted to from 22 to 25 per cent. It was found that the manic, or excited and expansive type of paretic, responded much better to the treatment than did depressed patients, which is just contrary to our view of that matter four years before.

At this time we are considering a group of six hundred patients, who have been treated since December of 1926. Without going back into figures and statistics too much, this whole group showed approximately 34.3 per cent, or 206 patients in the improved status; 40 per cent, or 240, after everything is considered with reference to condition, were unimproved; 154, or 25.6 per cent, died within from two weeks to two years after treatment. Now, in speaking of patients who are improved, the writer is indicating that these patients had a disappearance, gradually, of active mental symptoms, deluded states, hallucinatory experiences, marked irritableness and combativeness, with reduced to sometimes normal cell count, with negative globulin, and a slight lessening in the positivity of the Wassermann. Since 1926 the improvement appears to have gradually advanced from a point of about 12 per cent on up to the present figure, and these averages, as compared with others using malaria, appear fair.

NOTES ON THERAPY AND PROCEDURE

It has been observed that women patients terminate the malarial attacks spontaneously many times, and much more frequently than men. In fact, it appears that the spontaneous termination of the women is more the rule than the exception. With the men in our group, it is unusual to have such a termination.

The same strain of malaria has been used at Norwalk since 1926, and is the tertian variety, the paroxysms of chilling and febrile rise occurring every day. Quinin has terminated malarial attacks without fail, though occasionally there may be a recurrence which another course of quinin stops. In some individuals a follow-up course of neoarsphenamin or sulpharsphenamin has been given instead of quinin, which seems to work satisfactorily in terminating the malaria, and in providing the necessary tonic and alterative effect. In general, the follow-up treatment is supportive and tonic. Tryparsamid, neoarsphenamin, or sulpharsphenamin is used.

The patients who show arteriosclerotic changes, valvular heart disease, myocardial disease, nephritis, pulmonary disease, or marked general debility from any cause, are not good subjects. The arteriosclerotic group particularly do not go through the treatment well.

These patients are allowed to have a course of about fifteen chills and febrile attacks, and throughout their clinical condition are closely watched. The patient must be treated, and not just the disease essentially. The appearance of cachexia, general weakness, marked jaundice, are some of the indications to interrupt the malaria. We have to keep in mind that we are treating an individual already depleted by a grave disease, paresis, and that we have inflicted him with another disease, even though the object is remedial. In the well-selected subjects not weakened physically, or possessing some of the ailments pointed out heretofore, the treatment does not greatly deplete the patient; and between the chills and fever elevations, the patient appears to feel generally comfortable. If the fever mounts to a high point, the ice cap and plenty of fluids will render comfort, as well as the application of warmth during the chills. It is our experience that the temperature will range from 102 to 106 degrees. With a higher temperature, there may be some muttering delirium, restlessness or excitement, subsiding after the temperature goes down. Some patients had a very mild chill and mild febrile rise.

TECHNIQUE OF THE TREATMENT

Briefly, as to the technique of the treatment, one and one-half to two cubic centimeters of blood is drawn from the vein of the donor during his attack of tertian malaria, the blood being mixed with about one cubic centimeter of sodium citrate solution one per cent, and this mixture is injected into the vein of the patient. The subcutaneous method has not been used. We have had no instances in which death has followed shortly after the inoculation. The incubation period has varied from four days to ten, and even as long as twenty-one days, the average being approximately a week. The patients are put on a four-hourly clinical chart the fourth and fifth day after inoculation, and are kept closely under observation. The hour at which the attack comes is very carefully noted, since this may vary from day to day. The attack of fever comes daily as a rule, though there may be a variation as to its height on alternate days. The patient during the attack of shivering is made as comfortable as possible in blankets with local heat applied if necessary. During the sweating stage, the clothing may need to be changed. Liquids are freely given. There is a tendency toward constipation, and this must be corrected. Albuminuria may develop. If it is severe, the attack should be stopped. The blood for inoculation may be taken from the patient at any time as long as he has the malaria, and not necessarily during the febrile attack.

Blood examined from a patient during a chill shows a mature form of the malarial parasite, together with some younger forms. Parasites at different stages of development are seen. During the chill there appear two predominating types of the mature form, and the younger forms, which possibly accounts for the chills occurring every twenty-four hours. Examination of the blood in the same patient some twenty hours later following the chill, while it still shows many of the parasites in various stages of development, exhibits the older forms predominating with few of the young forms being seen. It is well to examine the blood from time to time, since it serves as a reliable guide along with the clinical signs of the progress of the disease.

IN CONCLUSION

With reference to just what factor is bringing about the betterment in these patients, it has been assumed and believed, with just cause, that the elevation of temperature accompanying the malarial attack was responsible for the benefits derived. Some hold to the view of a biochemical reaction coming about as a result of the malarial infection. Some of our patients who have had just mild chills and not a particularly high fever during their experience with malaria have enjoyed as substantial improvement as those with hyperpyrexia. Some patients who had extreme high temperatures have not seen as good improvement as those with milder fever. Speaking generally, it appears to us at this time—viewing this whole group of six hundred—that the patients who experienced the higher temperatures have had the better results. The exact nature of the process which brings about the improvements and remissions cannot definitely be assigned. The malarial attack may inhibit spirochetal activity in some manner not clear, aside from the thermogenic angle.*

SUMMARY

1. Spirochetes found by the Jahnel method in brains of six out of thirty-nine malaria-treated paretics.

* Spirochetal findings in brains of paretics treated with malaria, by Nicholas Kopeloff and Nathan Blackman, Department of Bacteriology, Psychiatric Institute and Hospital, New York City; American Journal of Psychiatry, July, 1933, pages 21 to 30.

2. Among six positives, degenerate forms of spirochetes encountered in more instances than normal forms. Three of six patients come to autopsy in six weeks after inoculation.

3. Spirochetes found by Jahnel and Dieterle methods in eight of ten paretics not treated with malaria.

4. Artificially induced malaria is likely to destroy spirochetes in brains of paretics; or, failing to destroy spirochetes completely, this therapy alters morphology of spirochete to such a degree as to render it degenerate in appearance.

Norwalk State Hospital.

DISCUSSION

Clifford W. Mack, M. D. (Livermore Sanitarium, Livermore).—The subject is covered in the author's paper in a very comprehensive manner. The large group of four hundred patients treated makes it possible to draw valuable statistical conclusions. It is stated that from 22 to 25 per cent of the patients are improved and stabilized. This accomplishment in the treatment of paresis, which has for years been considered well-nigh hopeless, is very noteworthy.

Another point brought out in the paper which should be emphasized is that, although there was not much improvement in the serology, nevertheless clinical improvement is the valuable thing and warrants the writer in stating that they are treating the patient and not the Wassermann. We have positive evidence that the malaria is efficacious in paresis by the autopsy findings. The article by C. Geary of the Central Pathological Laboratory of the London County Mental Hospitals cites several cases in which histological examination showed none of the characteristic findings in the brain tissue of paresis after the malarial treatment. These cases were positively diagnosed as paresis.

We should endeavor to obtain the consent of patients and relatives to administer the malarial treatment in the preparetic stage of neurosyphilis before degenerative processes have begun. This can best be accomplished by periodical spinal fluid examination in known cases of lues, so that the asymptomatic stage may be recognized and treatment administered accordingly.

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Samuel D. Ingham, M. D. (727 West Seventh Street, Los Angeles).—The results obtained by the treatment of general paresis in a State hospital, where the patients as a rule are in a relatively advanced stage of the disease, are not a true indication of the value of the treatment. It is obvious that the best results from any treatment can be obtained in an early stage of the condition treated, but it is seldom that patients are committed to the State hospital in an early stage of general paresis. It is very significant, therefore, that more than 33 per cent of a series of six hundred patients in the Norwalk State Hospital are definitely improved following the malarial treatment. The fact that these results correspond to the results from many hospitals and clinics has established the method as a distinct advance in the therapeutics of neurosyphilis. Although the author did not mention the after-treatment, it is well to remember that, after a patient has been treated by malarial inoculation or by other forms of hyperthermia, this should be followed by a prolonged series of treatments by bismuth and tryparsamid, checked by periodic examinations of blood and spinal fluid.

❋

G. Creswell Burns, M. D. (Compton Sanitarium, Compton).—In the past five years at Compton Sanitarium, we have treated twenty-six paretic patients by malarial inoculation. Twenty-four of these were patients who showed clear-cut symptoms of general paresis, while two were classified as belonging to the group of vascular central nervous system syphilis. Only three of the group were women. With such a small group statistics relative to percentages of recoveries, improved and unimproved states, can have little value. Some of these patients came to the sanitarium in the last stages of the disease. Some had had little or no antiluetic therapy prior to admission. Most of these patients were admitted soon after they had become unmanageable at home. In several instances symptoms of insidious parenchymatous involvement were present many months, occasionally two or three years, before a physician had been consulted. Five of our inoculated patients died. All but one of these were poor risks to start with, and the probability of a fatal outcome was explained to the relatives. The deaths were in the male group. No autopsies were obtained. One patient, forty-six, died from a cerebral hemorrhage the day following inoculation with malaria; so we do not feel that malarial inoculation was responsible for this death. In the other cases death occurred from eight to twenty-one days after inoculation. These four developed a terminal acute nephritis. One of these patients was thirty-eight, the remaining three over fifty, and arteriosclerotic.

Twenty of our inoculated patients were considered to be improved following the treatment with malaria. Only one was definitely unimproved. Of the improved group, three patients are known to be working. One of these was inoculated in 1929, one in 1933, and the other, a young man of twenty-five whose infection was congenital, was inoculated in February, 1934. He had received considerable antiluetic treatment periodically for several years. The onset of acute mental symptoms was in December, 1933. The young man returned to work this summer. One patient of the improved group became so clear mentally that a confusion over his identity resulted. Following malarial treatment he resented being called by the name under which he was registered. He remembered having a brother on the eastern coast of Canada and investigation resulted in our learning that this patient had been missing from his family for twenty-five years.

The diagnosis of general paresis had already been established in twenty-two of the twenty-six patients before admission to the sanitarium. Two were admitted because of alcoholism, one with a long-standing diagnosis of Parkinsonian syndrome, and the fourth, not referred by a physician, came in undiagnosed. Tryparsamid has been used routinely as follow-up therapy.

Bruetsch (The Histopathology of Therapeutic (Tertian) Malaria, in *The American Journal of Psychiatry*, July, 1932) has shown that therapeutic malaria, in addition to producing a stimulation in general of the reticulo-endothelial apparatus (system of histiocytes) leading to a new formation of macrophagic tissue in various organs, also produces a macrophagic response in the nervous system, greatest in the leptomeninges. To quote Bruetsch: "In the adventitial sheaths of the vessels of the brain cortex, the mesodermal phagocytes are only slightly stimulated. About middle-sized and large cortical vessels a small increase in the number of macrophages has been found. In the perivascular spaces of the large vessels in the white matter, and in the striatum, and in the pons, stimulated histiocytes are more numerous. The small mesodermal elements along the capillaries of the brain cortex have not been activated."

Since encouraging clinical results have been reported in paresis by the use of diathermy and the employment of high temperature baths, whether or not a similar macrophagic response is produced in these patients by fever alone is something for a work such as Bruetsch's to determine. Freeman (*Journal of the American Medical Association*, June 3, 1933), concluded, from necropsy material in six of his cases in his series treated by diathermy, that there was persistent inflammation in every one of the brains examined. But the amount of macrophagic response was not stressed by Freeman in this particular article. It would be interesting to treat a series of paretics with malaria and terminate the malaria after only two or three chills. If definite clinical improvement re-

sulted, it could reasonably be assumed that the macrophagic response was an important factor in the mechanism effecting these remissions. Certainly we do see patients obtain remissions following a poor malaria "take." One of the patients in our series was such an example.

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Doctor Van Meter (Closing).—The writer appreciates the discussion by Doctors Mack, Ingham and Burns, with reference to the additional points brought out by them. There can no longer be any question about the efficacy of malarial therapy in the light of all these experiences.

The paper was intended to deal only with malarial therapy and, for the sake of brevity, the after-treatment with the arsenicals and bismuth was not gone into. I may say that the patients afflicted with general paresis in the State hospitals, at least so far as Norwalk is concerned, are not all deteriorated, and some of them are not so far advanced, and I feel that our findings and work are very much of value in view of this. No doubt, the best results can be obtained by treatment in the early stages; however, what appears to be deterioration is not always such, or we would not have had such encouraging results.

HERPES ZOSTER—SOME OF ITS CLINICAL ASPECTS*

By Melvin R. Somers, M. D.

AND

Pearl S. Pouppirt, M. D.

San Francisco

Discussion *by Samuel D. Ingham, M. D., Los Angeles; Merlin T.-R. Maynard, M. D., San Jose; Hiram E. Miller, San Francisco.*

THE multiplicity of therapeutic measures recommended for herpes zoster points to a lack of basic knowledge for rational therapy of this condition. Rational therapy requires an understanding of pathology and more especially pathological physiology. Therefore, as a basis for a discussion of some clinical results we have obtained in the treatment of this condition by posterior pituitary extract, we shall briefly call attention to some of the pathological and physiological aspects of herpes zoster.

PATHOLOGY AND PHYSIOLOGY

In 1863, Bärensprung [1] first demonstrated that herpes zoster is accompanied by changes in the spinal ganglia. Since that time a great many observers have studied the pathological anatomy of herpes and have established that there are two types of the condition, known as primary and secondary. So-called *primary* herpes zoster is apparently an acute infectious disease which is accompanied by fever and leukocytosis, and has a self-limited course, usually followed by immunity. In this condition there is an acute inflammation [2] affecting mainly the dorsal ganglion of the spinal segment involved. Pathological studies of herpes zoster that occasionally occurs in the course of a great variety of other diseases, demonstrate that there is also a *secondary* type. These studies show that in the secondary type there is a lesion at some point in the reflex arc which extends from the spinal cord through the posterior roots and dorsal ganglia to the peripheral nerves and skin, or the lesion may be at any point in the viscero-sympathetic-spino-radicular arc.[3] Various chemical agents giving rise to herpetiform lesions, such as arsenic and carbon monoxid, have the common property of increasing the permeability of the capillaries.[4] The vascular changes have been so prominent that Peiffer and others have thought that the distribution of the skin lesions follows that of the blood vessels.

If one considers the many sites of the pathological changes found in herpes zoster, it is evident that any theory of the origin of the pain and skin lesions must be consistent with disease at any point along the reflex arc, and even in the blood vessels of the skin itself. The observation by Stricker [5] that vasodilatation occurs in the distribution of the posterior spinal root, when its peripheral cut end is stimulated, has been amply confirmed by Bayliss,[6] Langley,[7,8] and others. It is not within the province of this paper to go into the exact mechanism by which the capillary and arteriolar dilatation is produced. Vasodilator fibers may be stimulated acting directly upon the peripheral blood vessels, or the action may come about from antidromic impulses. According to Bayliss, it is the skin rather than the other tissues of the neural segment which is chiefly affected in the vasodilatation originating in antidromic impulses.[6] Lewis [9] has brought forth experimental evidence to show that the nerves do not act directly upon the skin vessels, but that there is a chemical substance resembling histamin in its action, liberated peripherally, and that this is responsible for the cutaneous capillary vasodilatation. The existence of a vasodilator substance is not accepted by everyone. It is possible, as has been suggested by Lewis [9] and others, that the arteriolar dilatation accompanying the capillary dilatation may come about as the result of an axon reflex. Anatomical connections have been traced between the nerve-endings and the adjacent blood vessels. Clinical and some experimental observations show that prolonged stimulation of sensory nerve fibers is accompanied by vasodilatation, and produces swelling, chemosis, and vesicle formation in the innervated area. That the vasodilatation, swelling and vesicle formation is accompanied by local irritation of sensory nerve-endings is a matter of common clinical observation. This type of pain may be relieved, as Bleuler [10] recommends, by the use of cocain ointment upon the lesions, demonstrating that it is due to peripheral rather than more central irritation. It is plausible, therefore, that once vasodilatation and chemosis have occurred, a local axon reflex takes place and adjacent blood vessels open up. Thus a vicious circle would be established, limited only by the intensity of the vasodilator stimulus either direct, antidromic, or reflex and the amount of vasodilator substance liberated, if one exists. The irritation of sensory endings by the local reactions preceding and accompanying the herpetic lesions is probably responsible for the type of pain with which

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we are concerned in this paper. It is not important from the standpoint of this discussion whether the virus of primary herpes zoster is localized peripherally in or near the skin lesions, or more centrally, or whether it travels along the nerves or their sheaths.

With the above pathological and physiological considerations in mind, it occurred to us that measures to control the peripheral vasodilatation so as to interrupt this theoretical vicious circle would be rational, and would also shed some light upon the causes of the pain and the skin lesions themselves. Peripherally acting vasoconstricting drugs seemed promising, and of those available two appeared to have definite clinical advantages, namely, epinephrin and posterior pituitary extract. Preliminary trials were made on a few cases, and from the first both drugs seemed to produce very favorable clinical results. It is interesting that in 1924 Duke [11] reported that the pain of herpes zoster might be controlled by adequate doses of epinephrin. He gave no details as to number of cases treated, or type of pain relieved, and made no attempt to explain the action of the drug in the disease. However, epinephrin has a very fleeting action, and the dosage must be often repeated; so that it was soon abandoned in favor of pituitary extract.

Vendel in 1923,[12] Sidlick in 1930,[13] and Niles in 1932,[14] each reported series of cases treated by posterior pituitary extract, with favorable effects either upon the pain or the skin lesions or both. None of these authors attempted any explanation of the action of the drug in herpes zoster, and neither did they specify what type of pain diminished. Niles mentions that his only failures were with postherpetic neuralgia.

We have treated twenty-two cases of definite herpes zoster, all with skin lesions and marked pain, by the use of posterior pituitary extract.

METHOD OF TREATMENT

As soon as the pituitary treatment was started, all other forms of treatment, both local and general, were stopped, except that a dry gauze dressing over the lesions was permitted in three cases. A complete history and examination, including a careful note of the exact site of the skin eruption and the number of vesicles present, were done in all cases before any pituitary extract was given.

Routinely, all patients received an initial subcutaneous injection of 0.2 cubic centimeter of posterior pituitary extract of the strength known as "surgical pituitrin." If there were no unfavorable symptoms noted, and none ever were, the initial dose was followed in thirty to sixty minutes by another somewhat larger dose. In the older patients, or those showing an initial systolic blood pressure of over 160 millimeters of mercury, the second dose was usually 0.3 cubic centimeter, and the third and subsequent doses, 0.4 to 0.5 cubic centimeter every one to two hours. The younger patients and those apparently in good physical condition received 0.4 cubic centimeter the second dose, and 0.5 to 0.7 cubic centimeter subsequently every one to two hours until their pain subsided. One patient, age twenty-seven years, received 1.0 cubic centimeter as the initial and only dose of the day. He complained of pallor, tremor, and abdominal discomfort, but the burning pain localized to the lesions was diminished within three hours. The average dosage received by young healthy patients was 0.6 cubic centimeter, which was well tolerated; although patients receiving 0.5 cubic centimeter or more noted pallor and some abdominal discomfort, both usually appearing within twenty to thirty minutes. One case was treated exclusively by "obstetrical pituitrin," intranasally, three to six drops every thirty to sixty minutes, repeated three times; then every two hours for five times. Three cases received "pitressin," given in the same manner as was the pituitrin, and their response was in every way typical of the group. One case received alternate doses of pitressin and pituitrin, and the results were within the general average of the group.

In all patients, as soon as pain was relieved, the interval between doses was increased and treatment administered only when the pain commenced to return. The time intervals from the administration of the first dose to the beginning of lessening of the pain, to the complete disappearance of the pain, and to the regression of the skin lesions, were noted in each case. It was found impractical to note the time interval when the skin lesions had completely healed, because of the difficulty of determining just when they were gone. The individual lesions responded differently, depending upon how elevated they were, how long they had existed and whether they were vesicular. It was much easier to note improvement rather than cure, because the lesions became more discrete, less elevated than the adjacent skin, and the surrounding flush disappeared.

Table 1 summarizes the cases treated and the results obtained.

PAIN

Only a few patients had been treated before the existence of two types of pain was noted, and most subsequent cases confirmed this observation. One type of pain was described as sharp, stabbing, shooting, or aching in character. It was sometimes constant, but usually intermittent or variable in intensity, and involved the affected segment to a varying extent. It was not often as well localized as the next type of pain. Four of the twenty-two cases had this pain in a marked degree, and three of the remaining cases in a mild degree.

The other type of pain was described as burning, itching, or stinging, and was usually well localized to the lesions themselves, although in common with the first type it sometimes preceded the skin eruption. The burning pain was present in some degree in all cases, and its intensity was roughly proportional to the severity and extent of the skin lesions.

The burning pain was uniformly relieved by the treatment. Always within six hours, and on an average of four hours after the initial injection of pituitary extract, all cases reported distinct diminution of this discomfort. Four patients noted lessening within thirty minutes after the

second dose (about one and one-half hours after beginning treatment). In twenty cases this type of pain was completely relieved in seven hours after the initial dose. One of the remaining cases, an hysterical female who understood English poorly, was never completely relieved, but it was apparent that the pain had lost its importance within four hours. The other case was a male with the entire left distribution of cervical segments seven and eight completely covered with vesicles or papules, which had existed for five days before treatment was started. Although the burning pain was much less within four hours after the first treatment, it did not disappear until eighteen hours later.

The diminution of the burning type of pain always followed the appearance of skin pallor. From one to four hours after the pallor became marked, this pain began to subside and continued to grow gradually less and disappear. The rapidity of its subsidence did not seem to be proportional to the degree of pallor. The pain appeared to be slower to disappear the more extensive the skin lesions, or the longer they had been present before pituitrin was commenced. However, cases with vesicles lost their burning pain in about the same length of time as those without vesicles, although in the former ultimate healing seemed delayed. Because of the relation of the pallor to the benefits, it would probably be best to reassure the patients who complain of it. However, in the series this reassurance was seldom given, because the psychic factor would distort the subjective response.

The burning pain is the symptom most often and bitterly complained of, and it is also the symptom most readily relieved by pituitary extract. This pain is also relieved by other vasoconstricting drugs, and in a subsequent paper we shall report on the use of adrenalin, ephedrin, levometasynephrin, and some others.

The stabbing, sharp, aching pains, however, show a different response following pituitary extract, and are, apparently, more difficult to relieve. Occasionally a patient who has been suffering severely from the burning pain as well as the stabbing type, will claim complete relief from all pain following treatment. This happened in two of our cases; but careful observation and inquiry showed that the major pain had been burning, and when this was relieved the other pain was so slight as not to be thought worthy of mention. It is the stabbing, sharp, aching pain that persists as so-called postherpetic neuralgia. In Niles's series the postherpetic neuralgia cases were the only ones that did not respond to pituitrin. We can confirm this observation with a reservation as far as a possible psychic benefit is concerned. It is probably the failure to distinguish between the two types of pain that causes some of the variation in therapeutic results in the literature.

SKIN LESIONS

The skin lesions also regressed rapidly following pituitary extract. On an average of six hours after beginning treatment, the lesions were seen to be becoming definitely more discrete and the surrounding redness was less. In three cases improvement could be noted within two hours. In no case did any new lesions or vesicles appear after pituitary extract was started, and the usual course of the eruption was to grow gradually smaller, flatter, and go on to complete healing. It was seldom necessary to continue treatment longer than three days; one case received four days, and one case five days of treatment. Four cases received treatment for only one day, five injections. In two cases treatment was stopped on the second day and the lesions began to enlarge and pain return; pituitrin was resumed twice a day for two more days, and the eruption promptly became painless and went on to healing.

If vesicles have formed, complete healing appears to be slower and scarring is apt to occur at the site of the vesicles. It is important, therefore, to begin and maintain vigorous treatment before vesicles have formed. As is well known, facial herpes is prone to result in scarring. Five of our cases were trigeminal herpes; three affected in the ophthalmic division. Two of these cases showed some subsequent scarring, but only at the site of vesicles. In the other case, treatment was started before the lesions had gone on to vesicle formation, but one very faint scar occurred at the site of the largest papule. The remaining cases showed no scarring.

TABLE 1.—*Summary of Data*

Total number cases treated—22.

Average duration of skin lesions prior to treatment—3.1 days.

Average duration of pain prior to treatment—4.5 days.

Age Incidence:

20-30 years	3 cases	50-60 years	2 cases
30-40 years	7 cases	60-70 years	3 cases
40-50 years	6 cases	70-80 years	1 case

Sex Incidence:

Males	14 cases	Females	8 cases

Site of Skin Lesions:

Fifth cranial nerve	5 cases	Thoracic nerves	12 cases
Cervical nerves	4 cases	Lumbar nerves	1 case

Types of Pain:

Burning pain	22 cases	Neuralgic pain	7 cases

Outline of Treatment with Posterior Pituitary Extract:

Average total dosage per case—4.9 cubic centimeters
Average single dose—0.6 cubic centimeter

Average interval between treatments:

First day—1.5 hours; Second day—4.0 hours; Third day—18 hours

Average number of injections per case:

First day—4.2; Second day—2.8; Third day—1.2

Response to Treatment:

Skin Lesions (22 cases):

Average time to onset of visible improvement—8 hours
Average total dosage to onset of improvement—1.6 cubic centimeters.

Burning Pain (22 cases):

Diminution within four hours	18 cases
Diminution within six hours	22 cases
Complete relief within seven hours	20 cases
Complete relief within twenty-four hours	21 cases

Neuralgic Pain (7 cases):

Completely relieved	2 cases
Partially relieved	2 cases
Unaffected	3 cases

Side Effects:

Pallor	22 cases	Abdominal discomfort	20 cases
Tremor	14 cases	Precordial discomfort	2 cases

Two of our cases had lesions in the palm of the hand and they were very slow to disappear, and the local pain was also not completely relieved until over twelve hours after it had disappeared from all other sites. Both the palmar skin lesions and the pain appear to be unusually resistant to the pituitary treatment. The most rapid regression of skin lesions is usually seen where the skin is the thinnest.

CONTRAINDICATIONS

The contraindications for the use of posterior pituitary extract may be best pointed out when it is remembered that the drug acts peripherally upon smooth muscle. The main danger is cardiovascular. Coronary occlusion has followed the injection of posterior pituitary extract in both animals and man, and the existence of severe coronary or myocardial disease should be looked upon as a definite contraindication to its use. Two of our cases noted mild precordial discomfort, but no bad effects were observed. Precordial pain should be taken as an indication to reduce the dose and frequency of administration of the drug, and, if severe coronary disease is suspected, its discontinuance entirely. The coronary arterial spasm is part of the generalized vasoconstriction which seems to be the objective of the pituitary extract treatment. It may be possible to avoid cardiac dangers by the use of one of the synthetic isomers of epinephrin which cause peripheral vasoconstriction without affecting the coronary arteries. We will take up these promising therapeutic measures in a subsequent paper which is now in preparation.

Gangrene has followed large doses of pituitrin,[15] so that one would hesitate to use it in the presence of circulatory impairment of the extremities, such as Raynaud's disease or thromboangitis obliterans. Arteriosclerosis of ordinary degree does not appear to be a contraindication. The elevation of the systolic blood pressure might cause arterial hemorrhage if there be severe arterial disease.

One would also hesitate to use vasoconstricting drugs in the presence of increased intracranial pressure where vital centers are already suffering from anoxemia. This is a point to be borne in mind because herpes follows intracranial operations at a time when the intracranial pressure may be considerably elevated.

The contraction of the smooth muscles of the gastro-intestinal tract is occasionally uncomfortable, but usually little else than reassurance is necessary. However, in the presence of irritation along the gastro-intestinal tract, actual pain might result and the use of the drug be limited. The danger of emptying a pregnant uterus can be easily avoided by using pitressin rather than pituitrin, and it seems to be equally effective.

We are indebted to Dr. Charles W. Barnett for allowing us to include one of his private cases in this series.

SUMMARY

Theoretical considerations based upon a study of the pathology and physiology of herpes zoster suggested that drugs causing peripheral vasoconstriction should produce beneficial therapeutic results. Twenty-two cases of definite herpes zoster, all with skin lesions and marked pain, were treated by the use of posterior pituitary extract. The burning, stinging type of pain began to subside in some cases as soon as two hours after initial injection, and was completely relieved in twenty cases within six hours. The sharp, stabbing, neuralgic type of pain was not so much affected. Improvement was noted in the skin lesion within six hours following the first dose of pituitrin. In no case did new lesions or vesicles appear after pituitary extract was administered. Regression of the skin lesions was slower in the cases with vesicle formation. The pain disappeared with equal rapidity, regardless of whether or not vesicles were present. The improvement of the skin lesions and the subsidence of pain followed soon after, and was roughly proportional to the vasoconstriction produced. There were no unfavorable effects.

CONCLUSIONS

1. Posterior pituitary extract is of definite clinical value in relieving the burning pain of herpes zoster.

2. It is of less value in relieving the neuralgic type of pain.

3. The presence of vesicles does not delay the relief from the burning pain.

4. Existing skin lesions regress, and new ones do not appear if pituitary extract be given in sufficient quantities.

5. Complete healing of the skin lesions is delayed in cases in which vesicles are present.

6. This method of treatment is generally applicable, provided the contraindications outlined in the body of this article are observed.

7. There is clinical experimental justification for the theory that the above beneficial effects are dependent upon the vasoconstriction produced.

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DISCUSSION

Samuel D. Ingham, M. D. (727 West Seventh Street, Los Angeles).—The importance of Doctor Somers' paper is indicated by the fact that twenty-two cases of primary herpes zoster have been treated, and twenty-one of them have been completely relieved within twenty-four hours. If such results can be obtained constantly by the use of surgical pituitrin, this treatment forms a distinct advance in deep therapeutics of herpes zoster. The hypothesis offered by the authors concerning the manner in which pituitrin operates appears to be reasonable. It still remains, however, a hypothesis. Sustained vasoconstriction at the skin areas of hyperemia and vesiculation may be the cause of relief. It must be remembered, however, that herpes zoster is a self-limited disease; that immunity processes are at work from the time of its onset, and that the injection of pituitary extract produces not only vasoconstriction but rather widespread effects involving the entire organism, especially the combination of the different endocrine functions and metabolic processes. To return to the practical aspect of this treatment, the fact that it gives relief to distressing, burning pain in such a large proportion of cases treated justifies extended observations over a larger number of cases. Due caution, however, should be observed in patients in whom there are possible contraindications.

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Merlin T.-R. Maynard, M. D. (407 Medico-Dental Building, San Jose).—In reviewing my own cases of herpes zoster, I find that although my treatment does not consist in the use of one substance in every instance, a summation of the results produces a close comparison to those of the authors'. Originally, I treated all cases with autohemotherapy. Latterly, I have combined surgical or obstetrical pituitrin with the whole blood, and have injected the mixture into the gluteal muscles. More recently, I have treated a series with intravenous sodium iodid prior to giving any other treatment. My reason for combining pituitrin with the whole blood was that I felt that there was less pressor action on the vascular system from the slower absorption. I have felt safer with this procedure in cases involving elderly persons. Furthermore, this method apparently protects the patient against the urgent peristalsis commonly found following the injection of pituitrin alone. The dosages I have used have been larger than those of the authors', since I have given a full centimeter at a dose. However, since the absorption is slower, the effects are probably comparable. I have had several striking cases of relief of pain, the most dramatic of which was that of an instructor of acrobatic dancing. He presented himself at my office at 1:30 o'clock in the afternoon suffering acute pain from a zoster in the gluteal area. He had spent a sleepless night and was expected to teach his dancing class at three o'clock the same afternoon. I told him that it would be impossible for him to do so, and that he must return home and stay in bed. I gave him an injection of pituitrin in 10 cubic centimeters of whole blood intragluteally. He came in the next day and told me that no further pain had been felt since a half hour after the injection, and that he had taught his dancing class against my advice. I repeated the treatment twice, and there was no return of pain and recovery was rapid.

The results of treatment in my own office cases, treated by internal means, give the following tabulation in a total of fourteen such cases. Healing cases were not included. Those receiving pituitrin and autohemotherapy combined gave an average of complete relief in two days. Those receiving pituitrin alone showed an average of complete relief in one day. A total of seven cases receiving pituitrin alone, or pituitrin and autohemotherapy, comprise this series. Those receiving sodium iodid alone, a total of seven cases, show complete relief in four days. My recollection of all cases treated through ten years of clinical work which includes a considerable larger number than those here recorded, is that pituitrin alone gives the quickest relief. The next most effective method has been the combination of pituitrin and autohemotherapy. I feel that the greater safety of this latter method is reason for recommending it. The use of sodium iodid alone usually gives no relief from pain. However, the lesions will commonly show rapid healing following its use.

It is rather bromidic to make the statement that a series of twenty, or even fifty, cases are insufficient to give conclusive evidence of the value of a treatment; however, the steps of the authors' investigation have followed a very direct path, and I believe that it is a path well worth following from the evidence so far presented.

I appreciate very much the opportunity to discuss this excellent paper, and believe that I can concur with the findings of Doctors Somers and Pouppirt.

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Hiram E. Miller, M. D. (384 Post Street, San Francisco).—Somers and Pouppirt have given us a concise review of our present knowledge of herpes zoster and a plan for rational therapy. It is difficult to evaluate the results of treatment in this self-limited disease, and to determine whether the pain and eruption disappear spontaneously or as a result of treatment. Ideally, a similar number of untreated cases should be taken as controls and the end-results compared. Practically it is difficult to obtain a sufficient number of patients with the disease to carry out such a plan. While we know in general the course and average duration of the disease, we frequently encounter mild cases in which the pain disappears spontaneously in a few days' time.

I began in 1930 using obstetrical pituitrin in the treatment of herpes zoster. I have found it to be of value in some cases, but not in all. I have given a larger dosage at longer intervals than reported in this paper. I am certain that the authors' dosage and time interval are preferable.

The pain in supraorbital zoster—especially in elderly patients—is particularly resistant to therapy. In some cases it continues for many months or throughout the lifetime of the patient. I have not found that pituitrin prevents this long period of suffering in all cases. I think that the authors have sufficiently stressed the dangers of pituitrin therapy in the aged and those with hypertension.

Pituitrin is definitely of value if given early in the treatment of herpes zoster. We are indebted to the authors for their presentation of this subject.

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Doctor Somers (Closing).—We have had some experience with the use of pituitary extract mixed with whole blood, and we agree with Doctor Maynard that the effects are not so prompt as with pituitrin alone. These cases were not included in our series because of the additional variable. We have not tried a sufficient number of cases with this combined method to draw any satisfactory conclusions as to its value.

We agree with Doctor Miller that the persistent postherpetic pain does not, as a rule, yield to pituitrin treatment. It is usually possible to identify the cases that will have favorable results by the type of pain

of which they complain. The burning postherpetic pain will probably get relief, but the neuralgic pain, in our experience, is not benefited by posterior pituitary extract. We have not found that the pain in supraorbital zoster during the acute stages is any more resistant to the pituitrin treatment than zoster of any other part of the body where the skin is of approximately the same thickness. However, supraorbital zoster frequently goes on very rapidly to formation of vesicles, and when this has occurred, healing is delayed and scarring is apt to follow. This again emphasizes the importance of early treatment.

THE LURE OF MEDICAL HISTORY*

THE FIRST SUTURE OF A BLOOD VESSEL†

By Frederick A. Fender, M.D.
San Francisco

THOUGH the report of the first successful suture of a blood vessel in man is often cited, it is quoted rarely and appears to have been seldom read. The feat that occasioned the report, the closure of a ruptured aneurysm, becomes noteworthy when one realizes that more than one hundred years elapsed before it was duplicated. The suture was carried out by Mr. Hallowell, a surgeon of Newcastle-on-Tyne, in 1759, and reported to Dr. William Hunter in a letter from Mr. Lambert (Figure 1) two years later, Hallowell meanwhile having died. Hunter made the letter public at a meeting of "A Society of Physicians in London." The communication is not long, and is perhaps worth reading in full. The method of suture, "as in the harelip," is illustrated in Figure 2.

"The case of the Aneurysm was indeed curious, and, I am in hopes, will prove useful; but I must not be too sanguine in its favour, till I have seen the effects of such an operation confirmed by several instances; till then, I would not be fond of saying anything of it in print, except you think, that as few of these injuries fall to any single man's share in the ordinary course of business, it would, by that means, afford a larger field to put others upon the tryal, so as to introduce the method sooner.

"If this be your opinion, I have no objection to giving any short account of it you may think proper. The history of it was thus:

"I had very carefully attended to the cure of three Aneurysms, for which the operation was performed by my late worthy friend and collègue, Mr. Hallowell. In one of them, after the operation was performed in the common way, by a ligature above and below the aperture in the artery, such violent pain and swelling, and inflammation, came on, as to threaten a gangrene. Bleedings, fomentations, poultices, &c. mitigated these symptoms; a plentiful suppuration ensued; the wound gradually healed, and the patient was discharged from the hospital with a weak arm, and a pulse much weaker in that wrist than in the other. This case, in particular, made me turn my mind to the operation for the Aneurysm, and made me wish to see it done with some alteration in the method, so as to make less disturbance in the circulation of the part. I recollected all that I had seen or read of the effects of styptics,

360 *Medical Obſervations and Inquiries.*

XXX. *Extract of a letter from Mr.* Lambert, *ſurgeon at Newcaſtle upon Tyne, to Dr.* Hunter; *giving an Account of a new Method of treating an* Aneuryſm. *Read June* 15, 1761.

THE caſe of the Aneuryſm was indeed curious, and, I am in hopes, will prove uſeful; but I muſt not be too ſanguine in its favour, till I have ſeen the effects of ſuch an operation confirmed by ſeveral inſtances; till then, I would not be fond of ſaying any thing of it in print, except you think, that as few of theſe injuries fall to any ſingle man's ſhare in the ordinary courſe of buſineſs, it would, by that means, afford a larger field to put others upon the tryal, ſo as to introduce the method ſooner.

If this be your opinion, I have no objection to your giving any ſhort account of it you may think proper. The hiſtory of it was thus:

I had very carefully attended to the cure of three Aneuryſms, for which the operation

Fig. 1.—First page of Lambert's report of the first successful suture of a blood vessel in man.

of pressure, and of ligatures in the cure of hemorrhages. I considered the coats and motions of arteries, and compared their wounds with the wounds of veins and other parts. I reflected upon the process of nature in the cure of wounds in general, and considered in particular, how the union of divided parts was brought about in the operation of the hare-lip, and in horses necks that are bled by farriers. Upon the whole, I was in hopes that a suture of the wound in the artery might be successful; and if so, it would certainly be preferable to tying up the trunk of the vessel. I communicated my thoughts to Mr. Hallowell, Mr. Keenlyside, and some other friends of the profession. A case of an Aneurysm from bleeding occurred, and fell to Mr. Hallowell's lot. I recommended the method I have hinted. He put it in execution June 15, 1759. Everything was done in the usual method, till the artery was laid bare, and its wound discovered; and the tourniquet being now slackened, the gush of blood *per saltum* shewed there was no deception. Next, two ligatures, one above the orifice, and one below, were passed under the artery, that they might be ready to be tied at any time, in case the method proposed should fail. Then a small steel pin, rather more than a quarter of an inch long, was passed through the two lips of the wound in the artery, and secured by twisting a thread round it, as in the hare-lip. This was found to stop the bleeding;

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany Department, and its page number will be found on the front cover.

† From the Department of Surgery, Stanford University School of Medicine.

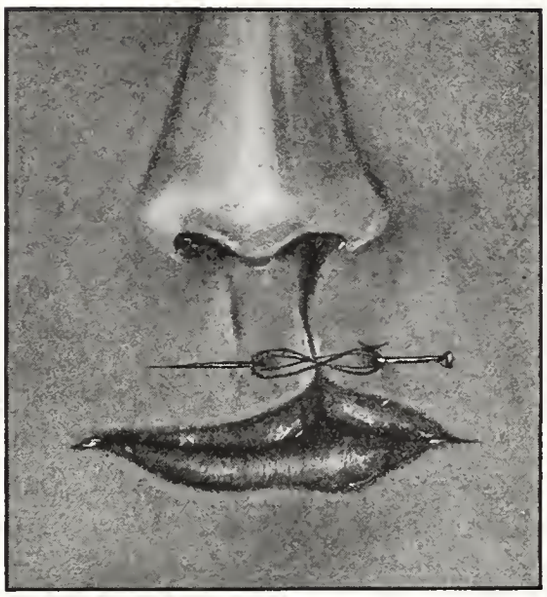


Fig. 2.—Method of suture of harelip referred to by Lambert. The edges were freshened, a long pin passed through both, and a ligature wound about the exposed ends of the pin in "figure-of-eight" fashion.

upon which the arm was bound up, the patient put to bed, and ordered to be kept quiet, &c. as usual in such cases. The wound was first dressed on the fourth day, viz. June 18. It looked well for the time, and continued to heal, without interruption, in a kindly manner. The pin came away with the dressings June 29, that is, on the fourteenth day; and on the 7th of July every part was healed, except what was kept open by the two ligatures, which remained loose in the flesh like two setons. These were therefore removed. In a few days after this, the wound was completely cicatrized: and July 19, the patient was discharged from the hospital perfectly well, and with a pulse in that arm nearly as strong as in the other. Indeed, the pulse was very little altered immediately after the operation; it was weakened in a small degree, as might be expected from the diameter of the vessel being straightened; but it was so strong and equal, that we had not the least doubt of the blood's continuing to circulate freely through it.

"If it should be found by experience, that a large artery, when wounded, may be healed up by this kind of suture, without becoming impervious, it would be an important discovery in surgery. It would make the operation for the Aneurysm still more successful in the arm, when the main trunk is wounded; and by this method, perhaps, we might be able to cure the wounds of some arteries that would otherwise require amputation, or be altogether incurable."

Lambert's hopes were not to receive early fulfillment. About ten years later, after extensive and painstaking animal experimentation, Assmann of Gronigen decided that the suture of arteries was not feasible. The project lay almost untouched for a hundred years, the importance of infection, the greatest obstacle to success, not being appreciated during the interval. Interest was reawakened by the experiments of Gluck in 1883. A few years later, with the advent of more radical surgery in Germany came, inevitably, accidents to large vessels and a new impetus to vascular surgery in man. The trail leads from this point, by way of significant American contributions, to Dörfler, Carrel and Guthrie, who may be said to be responsible for the accepted techniques of today.

Stanford University School of Medicine.

THE HEALTH FOUNDATION FOR RECOVERY†

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II*

INFLUENCE OF RECENT MEDICAL DISCOVERIES ON PRESENT-DAY LIVING

AND what is a reasonable and probable explanation for the continuous and uniform improvement in life-saving in the United States, while by other criteria of social status we would seem to be retrogressing or at least barely holding our own? The answer seems to me to rest in two major characteristics of the public health movement. No other department of local government is so exclusively concerned with the application of biology to social ends. Education has gradually replaced legislation, information based on experimental evidence has replaced traditional authority, the influence of intelligent self-interest has replaced the coercive power of the law. It is the introduction of the medical sciences into civil organization, and the use of learning instead of laws, which have distinguished the health department of today from all other functions of local government, except perhaps that of the public schools. In a notable address last February in Philadelphia before the American Academy of Political and Social Sciences, Dr. Thomas Parran, Jr., the health officer of the state of New York, expressed the gist of the matter as follows:

"Public health is founded upon scientific discoveries which are comparatively recent. There is an inevitable cultural lag between the acquisition of knowledge and its application to the community; and, although the desire for life and health is a basic human emotion, the absence of disease, the prevention of an epidemic, the saving of a life, are rated as negative accomplishments. They are not dramatized in the public consciousness. For a long time statesmen have expressed the thought that the care of the public health is a primary responsibility of government. Blackstone interpreted the legalistic aspect when he said, 'The right to the enjoyment of health is a subdivision of the right of personal liberty, one of the absolute rights of persons.'"

These concepts mean that the community collectively should perform for its citizens (1) those services which are so important to the social organism that they cannot safely be left to the initiative of the individual, uneducated or indifferent to their importance, and (2) those services which, because of their nature, the individual cannot provide for himself.

It is as characteristic of young functions of government as it is of youth itself that rapid growth of knowledge should reveal its vitality. Public confidence and support have followed closely upon satisfaction in the results already achieved. As soon as automatic or traditional belief has given way to a rational conviction in the new truths experimentally proved and practically demonstrated in village, city, and state, preventive

† From the Department of Public Health Practice of the De Lamar Institute of Public Health of Columbia University, New York City.
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medicine becomes the topic of the market place and the health officer becomes a prophet in his own country, rather than a sanitary policeman concerned chiefly with his legal rights and powers.

PRESENT-DAY CONCEPTIONS OF THE HEALTH FUNCTION OF A GOVERNMENT

The health function of government as at present conceived is to translate into action the discoveries of the laboratory and the clinic, to test and prove the innumerable factors which handicap life at any age, and put to work the resources of prevention. Among the guarantees of social stability, of permanence in the success of a representative form of government, responsive to the needs of the individual as well as to the will of the majority, is the fact that much ignorance of disease has been conquered, and that knowledge of the laws of health has been put into everyday use in the homes of most of our people.

CALIFORNIA'S PUBLIC HEALTH NEEDS AND RESPONSIBILITIES

What then are the characteristics of your own State in the community of commonwealths? What are California's peculiar needs and responsibilities, and how secure is your share of the west coast of the continent against invasion of bacteria and parasite, deterioration of stock, and the hazards of commerce and travel? What are the probabilities of population change, and a shift of balance of growth across the great valley and the mountains from the Atlantic to the Pacific basin?

In spite of the chronological youth of its organized government, California belongs among the more aged of the states having a higher proportion of its population in the decades beyond forty-five years of age than any but the New England states. While but 23 per cent of the people of the nation are forty-five years of age or over, in California almost 28 per cent are in this age group with Vermont, showing 29 per cent and the New Hampshire 30 per cent. This distinction of maturity is a dominant factor in creating the leading problems in preventive medicine for your physicians and health officers.

CALIFORNIA'S BIRTH AND MORTALITY RATES

Your very low birth rate is the natural accompaniment of your high death rate from heart disease and cancer. With a national heart disease death rate of 224, California's is 252, New Hampshire's and Vermont's just over 300. And similarly with cancer, the national death rate from which is 102, that of New Hampshire 135, and California 124.

And let me repeat that high death rates from heart disease and cancer in a population like yours is to be expected, is not at all discreditable, but in fact represents truthfully the degree of your success in saving infant and child life. We may learn to prevent and cure more cases of cancer, but to anticipate a reduction of deaths from heart disease occurring after the age of sixty would call for a bolder optimism than our present knowledge warrants.

Your birth rate will continue to fall, your general death rate will presently start to rise, and in the not distant future you will achieve a stable population probably before the nation as a whole ceases to grow.

There is now only one state, Oregon, with a birth rate lower than that of California. The birth rate of the nation in 1933 was 16.4, that of Oregon was 12.2, and that of California 12.4; with Washington (13.0), New Jersey (13.4), Connecticut (13.6) next in order. The four states with high birth rates are New Mexico with a rate of twenty-seven, and North and South Carolina and Utah with rates of twenty-three.

Even as early as 1950 you may expect a stationary population; after which there may be a decline such as we have reason to expect in New York State about the same time, even though the population of the nation may increase until about 1970.

It is estimated that England will be showing a falling population before 1945. It has been historical experience that when a people does not fully utilize its available natural resources it is presently displaced by some more vigorous or ambitious race.

There is, then, in the not too distant offing a challenge to keep our death rate still a little below our birth rate, and to see to it that the knowledge of contraceptive measures is spread among those races which now, from force of surplus populations and restricted area, look covetously upon our continental wealth and spaciousness.

It is true that today, as for many decades past, my own city and state of New York have grown at a relatively greater rate than have the United States as a whole. New York City is, in fact, the metropolitan center of this continent; and if national population becomes stationary the state of New York will draw many people from other parts of the country because of its superior advantages.

INFLUENCE OF THE GREAT WATER BASINS ON CIVILIZATION

It has been the teaching of history, however, that the great water basins have determined the growth and movement of populations. The Mediterranean and the Atlantic have had their turn, and it is to be expected that with the obvious awakening and restlessness of the peri-Pacific peoples your State may be called upon to adjust itself to a flow of strangers from overseas similar to that which has for a century and a half inundated, fertilized and made wealthy the ports of our eastern seaboard.

You and the nation behind you have suffered once and again from disease introduced from abroad, and you have carried the burden of tuberculosis brought in from other states. The tuberculosis death rate of California is eighty-one, while that of the United States as a whole is sixty-three, and that of New York City and State is sixty-one.

There is probably no greater sanitary contrast anywhere in the world than between the health conditions of this great San Francisco Bay area

and that of the unsewered hordes of your opposite neighbors across the Pacific.

Sanitary civilization such as England initiated, and we have achieved for but a bare majority of our people, begins with the lifting of man and his home out of the elemental slime of his own body excreta.

A vast and ancient people, learned, wise, cultured, deeply religious in their own way, as are the Chinese, have not been able to reconcile their urgent daily need of food with that cleanliness which seems to us a *sine qua non* of housekeeping and personal hygiene. There is a conflict of deeper concern than any between ambitious, proud, or jealous governments, but one which will surely and at no distant date succumb to the pacific penetration of the ideas of public health. When the Orientals have learned the lessons of sanitation and have availed themselves of the techniques and materials upon which population control depends, two great hindrances will have been removed which now justify our declining to welcome these people freely to share our social order and our government.

IN CONCLUSION

If the thought has not yet been expressed, and taken action through your State government, or by voluntary initiative, let me suggest to you that you follow the example of the Governor of New York State and create a planning board to consider social trends, as these are likely to affect your immediate and more remote future health.

Biology in government, which is public health, requires the vision of the seer, the calculations of the statistician, the practical wisdom of the trained executive.

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CLINICAL NOTES AND CASE REPORTS

FURUNCULOSIS OF EXTERNAL AUDITORY CANAL*

By Sidney H. Gidoll, M. D.
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AT casual glance it may appear quite superfluous to discuss such a trite subject as furunculosis of the external auditory canal; but careful consideration will indicate that some crystallization of thought is necessary anent the multiple therapeutic agents at hand for this common condition. The mere fact that so many different drugs are mentioned in the literature is in itself a confession of inadequacy.

SYMPTOMS AND SIGNS

When the patient presents himself, he complains of symptoms entirely out of proportion to the pathology found; the cardinal symptom being intense earache, often becoming so severe as to be unendurable. This pain is aggravated by any manipulation of the auricle, pressure over the tragus, or any movement of the mandible, such as mastication or yawning, which necessarily increases the pressure against the external fibrocartilaginous canal.

Inspection of the canal during the early stages may fail to disclose any objective finding whatsoever; or, at best, a small reddened elevation may be discerned at times. As the pathology is essentially an inflammation of a hair follicle or sebaceous gland, within the cartilaginous canal, careful exploration with a fine probe will disclose a point of exquisite tenderness. At this stage there has been as yet no liquefaction of pus, and abortion of the condition, without the necessity of incision, is often successfully accomplished by appropriate therapy.

MULTITUDINOUS THERAPEUTIC PROCEDURES

And it is concerning this phase of therapy that authorities differ; each one, apparently, advocating his own favorite procedure, which probably works well enough in his own hands. To give a slight idea of the variety of agents recommended, I will quote but from a few of the standard authorities and texts:

Politzer

Thirty years ago Politzer [1] suggested choice of the following:

(*a*) Aq. opii 4.0, aq. dest. 12.0.

(*b*) Five per cent cocain solution.

(*c*) Burow's solution (argill. acet. solut. Burowii, aq. dest., aa 15.0, cocain muriat. 1.0).

(*d*) The insertion of a long piece of solid fat (pig's), covered with a morphin-boracic acid salve (acid. boric. 1.0, vaselin 20.0, acet. morph. 0.2).

(*e*) Carbolic acid 0.5, glycerin 15.0.

(*f*) Boric acid 1.0, alcohol 20.0.

(*g*) Argill. acet. Burowii and aluminum acetico-tartaricum.

(*h*) Sublimate alcohol (hydr. muriat. corros. 0.05-0.1, spirit. vini rectif. 50.0).

Beck

Twenty years later, Beck [2] offered as his favorite procedure:

(*a*) A cotton tampon, dipped in pure alcohol, or

(*b*) Hot Billroth solution (lead acetate 1.0, alum 10.0, water 100.0), as gauze packing within the canal.

Kerrison

Kerrison [3] goes to greater trouble in the preparation of the canal prior to instituting his treatment. He cleanses the canal of all extraneous material by warm boric acid irrigations and then scrubs it out with cotton wound applicators dipped in 95 per cent alcohol. He then allows a pledget of cotton, saturated with carbolic acid 1:100, to remain within the canal for a minute or so. Following this, he inserts a wick of gauze which had been dipped in carbolic acid 1:300, and then wrung dry, and allows it to remain twenty-four

*Paper aims to present an evaluation of therapeutic procedures.

hours, changing it daily. If this does not cause an improvement in the condition, he inserts a gauze wick moistened in the following solution: acid, carbolic, gr. 1.0, sodii bicarbonat, gr. 20.0, glycerin, dram 1.0, aquae, qs. ad. ounce 1.0. It is with satisfaction that I note his warning not to use too much of this solution, lest maceration of the skin occur.

Phillips

Phillips [4] gets best results by first cleansing the canal, and then inserting a large tampon of cotton dipped in either a 50 per cent boroglycerid solution or, preferably, a solution of carbolic acid, 12 per cent in glycerin, which is allowed to remain within the canal from twelve to twenty-four hours.

Turner

Turner [5] feels that instillations of menthol in liquid paraffin (10 per cent) or of acetotartrate of aluminum (8 per cent) on a gauze wick, frequently give relief. He also uses carbolized glycerin, or 10 per cent ichthyol in glycerin.

Hays

Hays [6] cleanses the canal thoroughly, then swabs it lightly with tincture of iodin. He now packs lightly with a strip of gauze saturated in 4 per cent aluminum acetate solution.

Barnhill

When Barnhill [7] sees the boil in the very beginning, he can sometimes arrest it by sterilizing and cleansing the meatus with alcohol, and then painting it with tincture of iodin to which 10 per cent phenol has been added. He believes that the pain is relieved by using 10 per cent phenol in glycerin as a tampon.

Odeneal

Odeneal [8] blames the too faithful use of carbolic acid drops in the ear as causing a tendency to furunculosis, and he personally prefers a 5 to 10 per cent solution of aluminum acetate on a gauze wick within the canal.

Beck

Joseph C. Beck, in his contribution to Jackson and Coates,[9] suggests the use of dilute acetate of aluminum solution as a dressing within the canal.

Keeler

Keeler [10] first sterilizes the canal with cotton-tipped applicators dipped in boric acid solution, and then applies 70 to 95 per cent alcohol. He then inserts a gauze drain, impregnated with camphorphenol (camphor gum fifty-five parts, phenol forty-five parts). Ichthyol tampons are also applied.

Ballenger

Ballenger [11] utilizes as his abortive treatment, before the formation of pus, a 5 per cent solution of carbolic acid in glycerin. To lessen the pain he applies a saturated solution of aluminum acetate which, he states, softens the epidermis. He also avails himself of the gentian and acriviolet dyes.

Gleason

Gleason [12] advocates the use of cotton tampons, with yellow oxid of mercury ointment (six grains to an ounce of vaselin). He syringes the canal with warm 1:5000 bichlorid solution, or paints the canal walls with 12 per cent silver nitrate.

COMMENT

The above résumé gives some idea of the wealth of remedies offered for the abortive treatment of furunculosis of the ear. However, it would appear that the authorities are more or less agreed on carbolized glycerin or aluminum acetate, and these agents seem to be more commonly employed today by the average aurist. Kerrison [3] and Odeneal [8] both raise valid objections to the long-continued use of carbolic acid as tending to macerate the skin and prolong the staphylococcus infection. I have found the excessive use of aluminum acetate to produce the same result, and have discontinued it for that reason.

Borrowing an idea from the general surgeon, I have found alcohol and glycerin to answer every purpose in the abortive treatment of boils in the external ear. It does not macerate the skin, and appears quite effective in allaying pain and arresting the progress of the infection.

Given a patient with this condition, it is best to divide the treatment into systemic and local; giving the local first, because what the patient wants is relief, and that, immediately. Cleansing of the canal is performed very gently; using first a cotton-tipped applicator saturated in tincture of green soap, followed by one dipped in full strength tincture of iodin; and finally a tampon saturated in 65 per cent alcohol is allowed to remain in place for about five minutes. Care should be taken that none of these medicaments should trickle down the canal and touch the membrana tympani. These agents should sterilize the canal walls quite effectively, and that appears to have been the sole reason for the widespread use of phenol preparations heretofore.

A strip of gauze soaked in alcohol and glycerin (alcohol 65 per cent and glycerin āā equal parts) is now gently and snugly inserted into the canal, and a like prescription is given for home use: five drops to be instilled onto the gauze wick every hour in order to keep it moist. Hot applications, either dry—as an infra-red lamp or hot-water bag—or moist, as hot boric acid compresses—are now indicated, and are efficacious in allaying pain. These should be applied to the entire side of the head every hour for ten to fifteen minutes at a time. So much for the local treatment.

Now we enlarge our focus and look at the patient as a whole. Sedatives for sleep are indicated, and I have found none better than some barbiturate combined with amidopyrin, such as amytal grains one and one-half, amidopyrin grains three and one-half. Diet should be restricted to liquids, for mastication, as mentioned before, is quite painful. Fluids should be given in large quantities, not forgetting fruit juices.

To stimulate phagocytosis and raise resistance against the staphylococcic invasion, excellent results have been obtained from nonspecific protein

injections; choice being made between stock vaccines, leukocytic extracts or the like. An internist can determine the state of the general health and institute corrective measures as to diet and habits. Urinalysis is important, and at times a blood chemistry may be indicated for the etiologic organism in this condition is known to thrive best in a high blood sugar.

SUMMARY

1. Authoritative literature is reviewed as to therapeutic measures advised in the abortive treatment of furunculosis of the external auditory canal.

2. A plea is made to abandon the prolonged use of phenol preparations or aluminum acetate, since it has been found to cause maceration of the canal epidermis and a continuance of the furunculosis.

3. Alcohol and glycerin is advised in place of the above medicaments.

4. Attention is drawn to treatment of the patient as a whole, rather than concentrating all of the therapy to the ear alone.

516 Sutter Street.

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FRACTURES OF THE FOREARM OR LEG

A TRACTION MACHINE FOR FACILITATING EITHER CLOSED OR OPERATIVE REDUCTION

By E. W. Cleary, M. D.
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FRACTURES of both radius and ulna, or of the tibia and fibula, often present problems which, for their satisfactory solution, require stronger and more prolonged traction than the surgeon and his assistants can apply without mechanical help. To the surgeon who has wrestled with difficult operative reductions with cumbersome or incompetent traction devices, the advantage of a complete, easily sterilized machine, which puts the fracture under his complete control and leaves his field of operation unobstructed, is sufficiently obvious.

Universal traction tables of the Albee or Hawley type, because of their size, complexity and cost, have definite limitations and are often not available. The surgeon who treats fractures needs often a light, simple, easily assembled, inexpensive traction device that is widely adaptable. The ideal device should not be in the way of operation or fluoroscopy, should be completely sterilizable and easily disassembled into a small bulk convenient for carrying.

It is believed that the traction-bar assembly here presented meets reasonably well the above outlined, rather exacting requirements. A single bar is the simplest base upon which a system of integral traction can be set up. The earlier models of this device, which the writer made for his own use, were made of a single light bar of steel bent at either end so that the middle section was about 26 to 30 inches long. The shorter end sections, which extended parallel on the same side of the center section, were approximately 8 and 14 inches long. It was soon found that making the bar of sections of tubing gave maximum rigidity with minimum weight, and that tubing rectangular in cross section had advantages over cylindrical tubing.

DESCRIPTION OF THE APPARATUS

The model here presented, Plate 1, *A,* is made of light steel tubing approximately five-eighths inch square outside, coupled together with sections of solid steel bar of a size to telescope snugly into the tubing. The longitudinal piece is cut into two unequal pieces. For convenience in making adjustments as to length, an extra section 30 inches long (not illustrated) is provided so that a variety of lengths of traction base from 26 inches up to 56 inches may be set up. The side bars are 8 and 14 inches long. The traction screw *T* is one-fourth inch in diameter, and carries 6 inches of thread with a handle nut for adjustment and a wing nut for locking in any desired position of rotation. The aluminum shield plate, *S,* has two bar channels; the crosswise channel, *R,* being for adjustment of the shield plate to the anterior surface of the thigh, as in *C,* Plate 1, and *D,* Plate 2.

METHOD OF USE

Simple traction on a forearm fracture, *B,* Plate 1, is arranged by sealing the fingers of the injured arm, firmly closed over a padded loop of bandage or cord with adhesive which does not come above the wrist. The bandage loop is engaged in the hook of the traction screw and the shield plate firmly bound on the arm just above the flexed elbow. A thick felt pad beneath the bandage over the flexor surface protects the arm from injury during heavy traction. When reduction has been secured, plaster is put on from elbow to wrist, and allowed to harden. The traction bar is then removed, adhesive removed from the hand, and the cast extended above the elbow and down to the fingers.

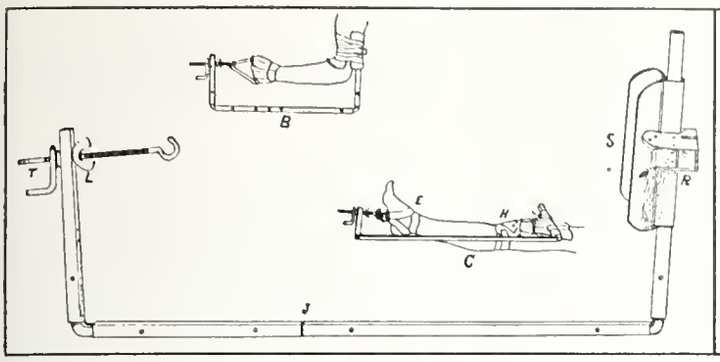


Fig. 1

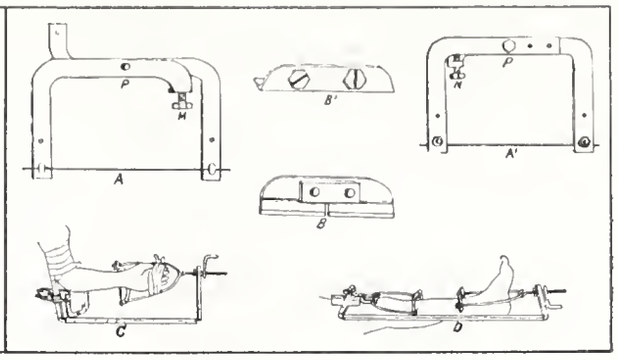


Fig. 2

Fig. 1.—Traction bar assembly; *S*, shield plate, reversible by use of bar channel *R*, for leg fractures; *T*, traction screw, lock nut *L*, when tightened, holds desired rotation; *B*, applied for closed reduction of forearm fracture—short adhesive holds hand closed; *C*, closed reduction leg fracture; *E*, ankle strap removable from under cast; *H*, knee strap.

Fig. 2.—*A*, self-tensing stirrups; *A'* hinge on bolt *P* and tense wire by tightening screw *M*; *BB'* retaining clamp, put on either end of wire; outside cast made snug to cast by bits of wet plaster bandage; stirrups off when cast hardens; *C*, transfixion wire traction on forearm; *D*, on the leg; bar not in the way of fluoroscopy; traction may be applied during operation. Entire assembly easily sterilized for operating.

Simple traction is applied to leg fractures, *C*, Plate 1, by use of the ankle strap, *E*, which is so made as to be removable after cast is applied well down over the malleoli. Counter traction is through the knee strap, *H*, Plate 1. This strong webbing strap goes twice around the leg below the patella, and laces through a leather pad anteriorly at each turn. The ends of the webbing are then made fast around the proximal arm of the bar where it emerges from the shield plate on the anterior surface of the thigh. The traction screw engages the hook on the ankle strap, *E*, and traction is applied. After reduction, plaster is put on from below the malleoli, and stops just short enough at the knee to permit the removal of strap, *H*, after plaster has set. The traction assembly is then removed and the cast extended over the foot, and above the knee if expedient.

If the bar is used as an emergency transportation splint on arm or leg, there must be ample padding beneath the shield plate and beneath all traction straps. Only very moderate traction should be applied.

This traction bar is particularly convenient for utilizing skeletal traction through tense transfixion wires, as illustrated in *C* and *D*, Plate 2. The self-tensing stirrups, *A*, *A'*, Plate 2, are simple devices for hooking up the wire and holding it tense. Each stirrup is made of two pieces of steel bar, one-fourth by five-eights inches, hinged together by the tap screw, *P*, and spread, after the wire is clamped in the wirelock bolts, by tightening the tap screw, *M*. This screw is threaded through the end of one arm of the stirrup and screws up against the other arm so as to increase the distance between the tips of the stirrup.

Both stirrups are provided with holes in either arm about one inch above the wire. Through these holes are passed the ends of bridles made of three-sixteenths inch wire. The ends of these bridles (see *C* and *D*, Plate 2) have each a long threaded section provided with wing nuts. This makes possible a wide range of lateral adjustment of either end of either bridle, giving ample opportunity for correcting alignment of fractured bones.

When traction is applied to the bridles, the stirrups are perpendicular to the long axis of the limb and the bridles approximately parallel to this axis. The bridle of the distal stirrup engages the hook of the traction screw. The bridle of the proximal stirrup attaches to the proximal side arm of the traction bar by means of a ferrule and clamp. When the distal wire is put through the os calcis, a much shorter bridle (not illustrated) is used on the distal stirrup, or the stirrup itself is hooked up directly to the traction screw. Prolonged traction may be maintained with this apparatus, but in most cases plaster is applied as soon as reduction is secured.

Wire-retaining clamps (*B*, Fig. 2) are fastened close to the plaster on either side to either wire, and their bearing surfaces made snug to the cast by using bits snipped from a plaster bandage. As soon as the cast has hardened so as to withstand the considerable strain of the tensed wires upon the retaining clamps, the stirrups may be loosened and removed, and the ends of the wires cut close to the clamps.

The writer uses unplated, oil-tempered spring steel wire of .0625 diameter. This wire is cut the desired length with a wire cutter, and a three-faceted trocar point made with a fine file. One may purchase as part of the equipment an adaptation of a simple mechanic's drill, which is admirable for transfixing with wire. No elaborate drill with wire guides is necessary. Due to simplicity of design and to the use of standardized materials, this entire assembly may be had at a fraction of the cost of the more pretentious machines.

490 Post Street.

TUBERCULOSIS SERVICE OF ALAMEDA COUNTY*

By Chesley Bush, M.D.
Livermore

THE tuberculosis service of Alameda County covers the diagnosis, treatment, and follow-up of indigent tuberculosis patients. It is not possible to speak of the county tuberculosis service without mentioning the tuberculosis service of the

* From the Arroyo Sanatorium.
A report to Alameda County Institutions Commission.

Alameda County Tuberculosis Association, which cares for the part-pay tuberculosis patients in conjunction with the Alameda County Medical Association and the tuberculosis service of the various health departments, including the Alameda County Health Department. All of this work, to be effective, must be coördinated and integrated. The county assumes the responsibility of this coordination, and it is done through the present medical superintendent of Arroyo Sanatorium, who has been placed in charge of county tuberculosis work, and the Social Service Department of Alameda County. One full-time social service coördinator is assigned to tuberculosis work, and in order to initiate and carry on this work the salary of this worker has been provided to date by the Alameda County Tuberculosis Association.

Deaths last year from tuberculosis were 308 in Alameda County. The number of clinic visits was 7,000 (or almost twice the standard), and the number of beds 334 (excluding Del Valle) or one bed per death. Despite the smaller number of beds per death, there has been no waiting list of any moment during the past year. The reason for this will be apparent as we proceed.

CLINICS

The clinics are three: at Thirty-first and Grove streets, at Hayward, and at Arroyo. The county's tuberculosis institutions are Fairmont (tuberculosis division), Arroyo, and Del Valle. We shall discuss them in the order named.

Thirty-first and Grove Streets Clinic:

This has become a consolidated clinic, as far as tuberculosis is concerned, including Berkeley and Alameda patients. The reason for this has been an available x-ray screen in the clinic quarters for the special use of lung examination. This screen not only has provided better examinations, but has saved the use of a tremendous number of celluloid films. The equipment was originally provided by the Alameda County Tuberculosis Association. The smaller number of patients in Alameda and Berkeley did not warrant the expenditure of money necessary to provide x-ray screen facilities there.

The clinic load approximated 650 visits per month, one hundred of these being pneumothorax treatments on patients who might otherwise be institutional cases. In 1932 the clinic load was about 250 visits per month, considering Oakland alone. This increase in load is due to four things:

1. A more intense campaign carried on by the Alameda County Tuberculosis Association and health departments for examination of contacts of known cases of tuberculosis as the best method of detecting early tuberculosis.

2. A more rapid turnover of institutions, and the treatment of more patients in their homes for a greater length of time.

3. A closer coördination between social service and relief agencies, by which Social Service is able to provide financially for the care of the patients in their homes not previously obtainable.

4. The inclusion of Alameda and Berkeley patients.

Hayward Clinic:

The Hayward clinic is operated every Friday morning. X-ray facilities are furnished by the Fairmont Hospital.

Arroyo Clinic:

The Arroyo clinic is operated every Monday afternoon in connection with the Pleasanton and Livermore health centers. Patients come to the sanatorium, and the sanatorium fluoroscopic screen is used. Recently a drive has been conducted by these two health centers in connection with the Alameda County Health Department, and the Arroyo clinic of late has examined every known indigent contact in relation to every known indigent case of tuberculosis in the district. The clinic load varies from two to twelve in an afternoon.

Tuberculosis Ward of Fairmont Hospital:

Tuberculosis patients at the Fairmont Hospital are cared for in the new south building, containing 140 beds.

Tuberculosis surgery is done at Fairmont, and the tuberculosis wards there have lost their old designation as a home for chronic tuberculosis, and now constitute a surgical hospital for tuberculosis, in addition to an admission ward for Arroyo. Patients are interchanged freely between Arroyo and Fairmont, and between the clinics and Fairmont, and thus the turnover for the south building is more than its entire population during the year. Last year averaged three patients per bed per year; that is, with 140 beds there were 315 discharges and 100 deaths. Not including deaths, the turnover averaged more than two patients per bed. There are from two to four lung operations every week. Many of these operations are for the rehabilitation of old tuberculosis cases, or at least an attempt to render them sputum-free if possible, so that they can be retained in the community without danger to their immediate neighbors.

The cost of patient care at Fairmont is $1.15 per day. As a matter of fact, the expense of the tuberculous patient is slightly higher than that of the average Fairmont resident, but the cost is well below the average of similar institutions. The State of California returns to Alameda County approximately $20,000 per year as a subsidy for tuberculosis patients in Fairmont.

Arroyo Sanatorium:

The population at Arroyo has been held constantly at approximately 180, with 145 of these adults. The turnover for last year was 241 patients, forty-seven of these being transfers to Fairmont for surgery or more surgery. This averages one and one-third patients per bed per year. More than half the patients at Arroyo are receiving pneumothorax compression with air, either on one lung or on both lungs simultaneously. This shortens the period of bed rest, and allows a certain percentage of these patients to be sent to their homes for continuation of treatment in the clinics. More patients are being given complete bed rest while institutional cases, and then sent home on becoming ambulant. No patient is suffering from lack of sufficiently prolonged care. No patient is discharged without proper Social

Service inspection of outside living conditions, and provision of extra care if necessary.

The beds in the children's department, retained for open cases of children's tuberculosis and bone and joint disease, have been completely filled only once during the year. This is the result, of course, of the decrease of tuberculosis infection throughout the country and also the decrease of the death rate. The death rate last year was 61 to 100,000. It is interesting to note that out of a county population of 400,000, not forty indigent cases of open children's tuberculosis needing institutional care could be found.

The cost of care at Arroyo is approximately $1.75 to $1.90 per day; and the State subsidy returned for Arroyo patients is $26,000 per year.

Del Valle Preventorium:

This institution has beds for eighty-five children. Its population has been fluctuant throughout last year, varying from fifty-five to eighty-five. As originally planned, this institution was for tuberculous children, or children who were contacts to known tuberculosis and remarkably under par. The demand for care of this sort of child has become less and less for a number of reasons:

1. The marked decrease in tuberculous infection.

2. The marked increase of care of under-par children of this type in schools, as a result of Del Valle demonstration.

3. The better diagnosis and segregation of children with open tuberculosis from closed cases; and the better diagnosis of tuberculosis in children in general, resulting in many being no longer considered tuberculous.

4. The better feeding of the indigent population by governmental agencies.

It has been considered best to reduce the number of preventorium beds in Del Valle, and to use existing facilities for the care of children convalescing from other illnesses, as an aid to Alameda County Hospital and other agencies now trying to meet the problem. These children can thus be cared for at a cheaper maintenance rate, and with more ideal conditions. In order to undertake this new work, one dormitory building has been remodeled, with the assistance of SERA labor, to meet hospital conditions.

The cost of care at Del Valle has been $1.10 to $1.20 per day per child; and it is expected that convalescent children can be handled for slightly more.

Preventorium children receive a State subsidy similar to that for tuberculosis patients, and the income from this source has been $7,200 per year, or one-third of the cost. This subsidy will not apply to convalescent care.

Alameda Medical Association—Part-Pay Patients:

When the Social Service Department of Alameda County certifies that a patient (not indigent) is able to pay in part for his medical examination, the case is turned over to the office of the Alameda County Tuberculosis Association. A social worker is attached to that office, and it becomes the duty of that worker to contact the private physician handling the case in order to (1) arrange for an examination and see that it is done; (2) assist the physician in the use of the best modern methods of diagnosis; (3) see that contacts are examined.

Each case results in several visits to family and physician, but is compensated for by the education in tuberculosis work given to medical men not hitherto interested in tuberculosis, as well as listing and providing social work for an important part of the population. Over one quarter of the Alameda County physicians have been contacted in this way.

Health Departments:

These comprise Alameda, Oakland, Berkeley, Emeryville, Piedmont, Hayward, Pleasanton, Livermore, and Alameda County, with their allied or non-allied school departments. County tuberculosis service must contact all these in coördination of follow-up work and examination of contacts, because treatment is so allied to prevention in tuberculosis work that no distinct separation can be made. Better organization of preventive health work administratively in Alameda County would solve many problems.

SUMMARY

County administration of clinics, as well as institutions, has made possible a greater use of existing facilities, both clinics and institutions. The further increase of compression therapy and surgical treatment of tuberculosis has also increased the turnover of patients. Every county bed for tuberculosis, not including Del Valle where the turnover is naturally greater, was used approximately one and six-tenths times during the year, and twice, if deaths are included as a discharge. For a tuberculosis service this is a very rapid turnover, and illustrates the fact that institutions are no longer boarding homes for the tuberculous.

Clinic visits approximated more than the standard generally accepted, namely, fifteen per death. This is true because of much pneumothorax compression treatment carried on in the clinics as well as a steady routine of examinations of patients discharged from institutions and examinations of contacts to known cases of tuberculosis.

Arroyo Sanatorium.

Advise Doctor's Examination for Breast Lumps.—A lump in the breast cannot be cured by massaging or by neglecting it in the hope that it will go away, declares Dr. Norman J. Kilbourne. Massage, instead of curing, breaks the wall that nature has tried to build around the tumor to prevent its spread. Massaging squeezes the tumor cells into the circulatory system.

Because lumps in the breast are seldom painful, women who have them neglect to see a doctor. However, cancer of the breast usually starts without any pain at all; and then when the pain does come, it is often too late for cure. Patients with a lump just starting in the breast have ninety-three chances out of one hundred of being well five years later.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

TRAUMATIC RUPTURE OF THE BLADDER

ETIOLOGY AND DIAGNOSIS

CHARLES PIERRE MATHÉ, M. D. (450 Sutter Street, San Francisco).—*Etiology.* The detection of traumatic rupture of the bladder can usually be made by the employment of the modern and special urological methods of investigation now at our command. But there are times when its diagnosis is difficult.

Rupture of the bladder should be suspected in an individual presenting the history of recent trauma produced by an automobile accident, a straddle fall, gunshot wounds, or by surgical intervention on structures contained within the pelvis, in which the patient suddenly develops shock, hematuria, vomiting, pain, tenderness and tumefaction of the lower abdomen, tympanites, difficult and painful urination with or without retention of urine.

The signs and symptoms facilitating its diagnosis may be divided into (1) general and (2) urological.

Signs and Symptoms.—General: Following large tears of the bladder, the patient is usually acutely ill, presenting pain, vomiting and the signs of shock and sometimes peritonitis. The lips are cyanotic, the face is pale, the pulse is rapid and blood pressure lowered. In patients in which the tear has extended through the peritoneum, the signs of peritonitis are also present. In these, urine collects in the abdominal cavity slowly, and shifting dulness occurs rather late. Tympanites soon develops, and is a sign of peritonitis resulting from intraperitoneal tears and extravasation of urine into the abdominal cavity. But in patients presenting smaller tears, the general symptoms are less marked or entirely absent.

Urological: Hematuria is a constant symptom. It might also be due to rupture of the kidney, and this should be borne in mind in making a differential diagnosis. It consists of the passage of bloody urine, or free bleeding from the urethra. The patient complains of strangury. He often has an intense desire to urinate, with the result of passing a little bloody urine or pure blood. The passage of pure blood is more often observed in cases in which there is a concomitant tear of the urethra. In cases of smaller ruptures, dysuria accompanies the passage of bloody urine. Retention of urine may be partial or complete. It is usually complete in cases in which the urethra has been entirely separated, and in those presenting large perforations of the bladder. Partial retention may accompany smaller tears and it may be due to spasm of the vesical sphincter. Pain and tenderness in the region of the bladder is a constant symptom of intraperitoneal rupture. Tumefaction varies as to the location and extent of the tear. It is due to extravasation of urine which follows the fascial planes. In extraperitoneal perforation, tumefaction might occur in the space of Retzius and might extend to the perineum or thighs. In intraperitoneal rupture tympanites occurs early, and is a differential point in distinguishing it from extraperitoneal tear. In intraperitoneal rupture distention soon occurs and rapidly involves the entire abdomen. The presence of urine in the abdomen causes infection which quickly results in peritonitis, with its characteristic signs and symptoms.

Diagnosis: Traumatic rupture of the bladder should be suspected in a patient presenting pain and tumefaction in the region of the bladder, hematuria, difficult painful urination, etc., following trauma caused by automobile accidents, falls, gunshot wounds, etc. The diagnostic sign, consisting of the injection of fluid into the bladder by means of a catheter for the purpose of detecting if it all returns, is usually of definite value. And yet it might lead one to an erroneous conclusion; for in some cases of rather extensive tear of the bladder it is not uncommon to recover the entire amount of fluid that has been previously injected. This occurs in cases in which the fluid passes through the tear into the cul-de-sac, peritoneal cavity, or scrotum (the latter in cases of urethral tear), and in those in which a piece of intestine or omentum has occluded the aperture. Rectal examination enables one to palpate collection of fluid in the cul-de-sac.

A plain roentgenogram gives one the opportunity to visualize the extent of fracture of the bony pelvis, and the presence of small spicules of bone that may have perforated and found their way into the bladder. A cystogram, preferably performed by the injection of non-irritating iodid compounds, commonly used in performing intravenous urography such as uroselectan, neo-iopex, skiodan, etc., is of some assistance. In smaller tears, little or no change in the contour of the bladder is seen. In larger tears, the location and extent of the extravasation can sometimes be determined. One should not be confused with pressure defects in the bladder caused by calculi, tumor formation or an obstructing prostate. An objection has been raised against the use of these opaque fluids for the reason that they may set up irritation and lead to infection. Intravenous urography, although of aid in many cases, is valueless in those presenting shock, as the iodid preparation is not excreted by the kidneys in these patients. Some men employ air as a contrast medium. From 50 to 500 cubic centimeters of air is injected into the bladder through a catheter by means of a syringe. In intraperitoneal rupture, the air enters the abdominal cavity and presses the bowels and liver away from the abdominal wall. This is observed through the fluoroscope, and on assum-

ing the vertical position air can be seen to collect under the diaphragm. In extraperitoneal rupture, the air escapes into the loose perivesical areolar tissues and is detected where it has spread along fascial planes. Although the injection of air might be of aid in early detection of bladder rupture, we advise against its use as a diagnostic procedure, because of the danger of air embolus which might be followed by grave symptoms and even death.

In certain patients in whom rupture of the bladder has been suspected, and where there is little accompanying shock, and in whom the urethra has not been injured, cystoscopy might be performed. Extensive hematuria, however, will often prevent cystoscopic visualization of the bladder wall. Furthermore, small tears may be overlooked as the tear usually does not extend straight through the bladder wall, like an incision made by the scalpel, but extends in and on different planes between the muscle layers. With some borderline cases, one is obliged to resort to an exploratory operation in order to establish the diagnosis, and to give the patient the benefit of early surgical relief. Indigo carmin injected intravenously, prior to the intervention, will facilitate location of the tear.

Acute alcoholism confuses the clinical picture and renders the diagnosis more difficult, as it might simulate all the general symptoms caused by rupture of the bladder. In these cases difficulty of urination, hematuria, tumefaction, etc., should point the way to a correct diagnosis.

In conclusion, I might state that, although traumatic rupture of the bladder can usually be detected by the general practitioner as well as by the urologist, more care must be exercised in making a differential diagnosis. Of great assistance is the history of preëxisting trauma, and a careful consideration of the general and urological symptoms noted above. The objective findings of hematuria, tenderness and tumefaction in the region of the bladder, difficult and painful urination with partial or complete urinary retention, point toward extraperitoneal rupture. In these cystoscopy and a roentgenographic examination, including cystography and intravenous urography, are of great aid. The presence of shock, accompanied by the passage of a scant amount of bloody urine or pure blood, abdominal distention, tympanites, should lead to the diagnosis of intraperitoneal rupture. In these it is dangerous to employ the highly specialized urological methods of investigation such as cystoscopy, urography, etc., and one must depend upon clinical signs and symptoms in order to establish a diagnosis.

* * *

DIAGNOSIS AND PROGNOSIS

Clark M. Johnson, M. D. (384 Post Street, San Francisco).—Rupture of the bladder is still a serious lesion with a high mortality. The mortality, as has been stated for years, depends primarily upon the length of time elapsing between the accident and its recognition. The early diagnosis of rupture of the bladder depends upon two definite factors: first, the lesion must be suspected; second, this suspicion must be confirmed or ruled out. With our present-day facilities, the diagnosis usually can be made readily within a few hours. Since this is true, the clinical findings obtained from the history and physical examination which point toward rupture of the bladder must be well known, and constantly borne in mind when examining the injured patient.

Clinical Findings.—There are two types of bladders which may be ruptured—the normal and the pathological. The history of previous urinary disturbances, from which one might suspect tumor or ulcers of the bladder, plus the further information that the trauma suffered was slight, should put one on guard. The urologist who has been treating patients for tumor or ulcer of the bladder usually sees these cases, and the diagnosis should be made immediately. These ruptures may be either intraperitoneal or extraperitoneal, depending, of course, upon the location of the lesion.

Rupture of the normal bladder may not be suspected so readily, if there are other severe injuries present. However, the history (if obtainable) as to when the patient last urinated, and whether or not there has been blood in the urine since the accident, is of great importance.

The history may be inadequate or fail to suggest rupture of the bladder. The next step in examination of injured patients—the physical examination—may lead one to suspect rupture of the bladder either in the presence or absence of other injuries. The findings may vary with intraperitoneal or extraperitoneal rupture, and are therefore given separately.

Intraperitoneal Rupture.—If the patient is seen within a few hours, shock and suprapubic and abdominal pain are the most constant clinical symptoms. The degree of shock depends upon the presence or absence of other lesions, the age and general condition of the patient, and whether or not he has taken drugs or alcohol to excess. Abdominal and suprapubic pain in the conscious patient is almost a constant symptom, with guarding of all abdominal muscles and general abdominal tenderness, greatest just above the pubes. The demonstration of free fluid in the peritoneal cavity, together with other presumptive symptoms and signs of rupture of the bladder, is significant. If, in addition to this, there is a constant desire to void, with tenesmus and the passage of no urine or only a small amount of blood-tinged urine, the picture is nearly complete. As time progresses, the abdominal and suprapubic pain may become less, but the rigidity becomes more marked and distention begins; the pulse becomes rapid and of poorer quality (more marked if there is profuse bleeding), and profuse, clammy perspiration is evident. The patient has the anxious look seen in patients with peritonitis from other causes. In later stages (after twenty-four hours), the shock is still greater, and all of the above signs and symptoms are increased. There may be ileus with vomiting, suggesting intestinal obstruction, or signs of uremia from peritoneal absorption of urine. Increasing fever and leukocytosis are present from the onset. In severely injured patients, who are in shock because of other lethal injuries, there

may be no evidence to suggest rupture of the bladder, the resultant low blood pressure from shock producing an oliguria with little or no extravasation of urine. The clinical signs and symptoms may become evident, as the patient recovers from the shock, and should be watched for.

Extraperitoneal Rupture.—The initial shock, in cases of extraperitoneal rupture, is usually less than in those of intraperitoneal rupture, unless the complicating injuries are great. Pain is a constant symptom and is referred to the pubic region, either in the midline or more to one side or the other, depending upon the location of the tear. There is always tenderness in this region. The patient is more apt to void and may have few urinary symptoms, although the urine is usually bloody at first. Later (after twenty-four hours), the signs and symptoms of infection are more evident, even more so than with intraperitoneal rupture, as the peritoneum can handle urine or infection better than the retroperitoneal tissues. Tenderness increases, and bulging or induration may be made out over the extravasation. The temperature and leukocytosis rapidly mount, but the patient is less shocked than with intraperitoneal rupture. The picture is that of toxemia and develops slowly or rapidly, depending upon the size and location of the tear.

The foregoing is not new and is important only in that it leads to suspicion of rupture of the bladder. I repeat, then, that the most important point in diagnosis of traumatic rupture of the bladder is that it must be suspected from the clinical evidence in the individual case. Once there is any suspicion of rupture of the bladder, this suspicion must be confirmed or ruled out immediately. The mortality mounts from 5 to 10 per cent, when the condition is diagnosed and treated early, to 40 per cent after twenty-four hours' delay. Bloody urine, obtained upon catheterization of severely injured patients who are unable to void, may be the only early lead to the diagnosis. Inability to pass a catheter on a patient who has not voided, or who has bled or passed bloody urine, usually means rupture of the posterior urethra, and this frequently is a complication of fracture of the bony pelvis. Rupture of the kidney also may produce bloody urine, but the clinical findings of this condition—pain in the flank, with increasing swelling in this region and evidence of trauma over the kidney (ecchymosis)—may be sufficient to differentiate between the two lesions. However, if there is still a reasonable doubt, the following steps for positive recognition of rupture of the bladder will settle the issue.

The Physical Proof of Rupture of the Bladder.

1. One of the earliest and poorest tests, still given clinical significance by some, is the introduction into the bladder of a measured amount of fluid and measuring the amount returned. If there is a great discrepancy between the amount injected and the amount returned, it has some clinical value. However, a contused and bleeding bladder may contain clots, and these clots may plug the catheter and interfere with the return of fluid, and the bladder may still be intact. Likewise, bleeding into the bladder from a ruptured kidney may interfere with the test. On the other hand, with small ruptures the entire amount of fluid may be returned. In other words, if this is the only test made, and the clinical picture is not taken into consideration, the diagnosis may be missed or delayed, which is fatal.

2. Cystoscopic examination may be resorted to. The bleeding may be so profuse as to make an adequate examination impossible and the site of rupture may be missed. The bleeding may have stopped and the cystoscopic examination reveal nothing except a blood clot which cannot be dislodged (as in a personal case, in which operation revealed a large intraperitoneal tear with a clot plugging the opening). A piece of bowel or omentum may do the same. On the other hand, if the tear can be seen, the diagnosis is definite and surgery can be instituted at once.

3. The injection of some opaque medium (sodium iodid, neo-iopax, skiodan, etc.), through a catheter, followed by an x-ray picture, may make the diagnosis. It is desirable usually, especially in cases of extraperitoneal rupture, to empty the bladder after the injection, and take a second film which may reveal extravasation not seen in the first picture.

4. Roentgenograms, taken after the bladder has been filled with air through a catheter, may show the air in the abdominal cavity extending up to the diaphragm in intraperitoneal ruptures, or the air may be seen to escape into the tissues around the bladder in extraperitoneal ruptures. There may be some difficulty, however, in differentiating the air from gas in the bowel. Mathé judiciously has cautioned against forcible injection of air into the bladder, because of the possibility of producing an air-embolus. However, this complication is less likely with a ruptured bladder, where the air can escape without undue pressure, than it is in an intact bladder.

5. Occasionally, the x-ray machine is not available at the moment, or it is not wise to move the patient. In two recent cases, air was injected slowly with no great pressure into the bladder and, by listening to the abdomen with a stethoscope after the injection had stopped, it was heard to escape into the peritoneum. The hissing or bubbling sound is unmistakable through the stethoscope even to a urologist. Both of my cases were intraperitoneal ruptures. I do not believe this test would be of value in extraperitoneal ruptures.

6. Occasionally, intravenous urography may be resorted to. This procedure is of value only when the patient is in fairly good condition and excreting urine. One must wait until the media is excreted by the kidneys, and frequently until the patient has voided or has been catheterized before the extravasation will be evident. It is apparent that this method is time-consuming, and requires numerous x-ray pictures. Its chief value would seem to be in those rare cases in which it is difficult to distinguish between a rupture of the kidney and a rupture of the bladder, or where both may be present.

Prognosis.—The prognosis depends entirely upon the presence and degree of other injuries,

and the length of time between the rupture and proper surgical intervention. Considering rupture of the bladder by itself, the older figures of a mortality of 60 per cent or more are unthinkable at present. It is true that patients with extraperitoneal extravasation of urine have a better chance when operation is delayed than do those with intraperitoneal rupture. Patients whose bladders are infected at the time of rupture, whether the rupture is intraperitoneal or extraperitoneal, have a graver prognosis than the patients with normal bladders and sterile urine. However, after twenty-four hours the mortality jumps from about 10 per cent to 40 or even 50 per cent.

In conclusion, the mortality can be lowered only by early recognition of the condition. Such early recognition depends primarily upon the ability of the physician (because of his familiarity with the history and the cardinal signs and symptoms of rupture), to recognize the possibility that rupture may have occurred. Which of the mechanical tests is used is often of less importance than clinical judgment and the ability to evaluate them. There is nothing more important than clinical judgment, borne of experience, and the instrumental, mechanical tests, when negative, may be disregarded by the experienced emergency surgeon in the best interests of the patient. Finally, in spite of what has been written about the dangers of spreading infection by the passage of catheters and cystoscopes, and the injection of various fluids and air, an early diagnosis with immediate surgery gives a lower mortality than does "aseptic delay."

* * *

SYMPTOMS AND TREATMENT

J. C. Negley, M. D. (527 West Seventh Street, Los Angeles).—*Symptoms.* Since this condition is generally accompanied by other results of trauma, such as fracture of the bony pelvis, fracture of the femur, abdominal injury, etc., no simple and applicable symptoms pointing directly to bladder rupture are present. Many of the symptoms may be masked by shock or unconsciousness.

1. Occasionally, patients will say they felt something give way in the lower abdomen.
2. Pain over bladder is always present.
3. There is always a desire to void, amounting to tenesmus at times; but as a rule very little or no urine at all is passed.
4. If rupture is intraperitoneal, it is always accompanied by vomiting, pain in abdomen and shock.
5. Extraperitoneal ruptures show no peritoneal irritation. There may be pain in the perineum, penis or legs.

All of the above are from more or less severe external violence such as blows, auto accidents, falls, etc.

If rupture occurs during instrumental manipulation of the urethra or bladder, as in sounds, cystoscopy, operations, etc., the symptoms are clear, concise, and classical.

1. Pain over the entire abdomen, coming on suddenly as from a blow, even with spinal or inhalation anesthesia and despite as high a dose as one-third grain of morphin, is always present
2. Shortly intense pain in either or both shoulders comes on; this is even more intense than the abdominal pain.
3. Nausea, vomiting, and shock immediately if rupture is intraperitoneal.

It is difficult, indeed, to picture by words the extreme degree of shock and pain that almost immediately follows this type of rupture.

Treatment.—While the symptoms of bladder rupture may be vague and misleading, no such uncertainty exists as to the treatment. Immediately on diagnosis, or even strong suspicion, of a ruptured bladder, suprapubic cystotomy should be done, regardless of whether it is extra or intraperitoneal.

First, a cystotomy wound in a clean portion of the bladder wall; closure of rupture if it is clean and easily accessible, rubber tissue or iodoform cigarette drains in the prevesical space, making sure that the bottom of all possible cavities are reached by the drains. A drain in the peritoneal cavity, by stab wound, in intraperitoneal ruptures is always imperative.

Even in extreme shock, a cystotomy under local anesthesia or a Day trocar procedure, is better than waiting for shock to disappear; for such conservative attitude more often leads to the increase of shock.

All of the foregoing may seem radical to some of the more conservative, but statistics and figures show that of a total of 169 collected cases prior to 1894, the lowest mortality rate, 30.8 per cent, occurred in those cases operated on within twelve hours after injury. Mortality rate increases from the twelfth hour on to reach 52.3 per cent.

After 1894, in forty-six collected cases the lowest mortality rate, 11 per cent, again occurred in cases operated on within twelve hours after injury. Mortality rate again increases to reach 43 per cent in those cases operated on after forty-eight hours.

In 1927, I reported thirty-four cases (from 1916 to 1927); fourteen were extraperitoneal and of these four died, a mortality of 28.6 per cent. Three of the deaths occurred in cases operated two, three, and five days after occurrence of injury. The remaining fatal case was operated on two hours after injury, but death occurred from torn pelvic blood vessel and cannot be attributed to either operation or rupture.

Intraperitoneal ruptures, twenty cases. Fatal cases, four, mortality 28 per cent. Operation following injury: in forty-eight hours, two cases; in fifty-six hours, one case; in seventy-two hours, one case.

In localities remote from modern hospital facilities, one might be justified in the use of an indwelling catheter per urethra, bladder lavage, supportive and other conservative measures. However, when good, bad, or indifferent hospital facilities are available, immediate cystotomy, drainage and other surgery as indicated is of paramount necessity, and will lead to more successful after-results, and a distinct and definite lowering of the mortality rate.

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Leaflet Regarding Rules of Publication.—California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

ANNUAL SESSION AT YOSEMITE: MAY 13-16

Final Plea for Attendance.—This is a "last call" for the annual session of the California Medical Association, to be held this year at Yosemite National Park, commencing Monday, May 13 and continuing through Thursday, May 16.

Last month's issue of CALIFORNIA AND WESTERN MEDICINE contained the complete scientific and other programs, together with the "Pre-Convention Bulletin" reports of officers and committees; and it is to be hoped that the information therein has already induced many members, who had not contemplated attendance, to change their plans and go. All that has been said of the anticipated pleasure and value of this year's annual session still holds true. Members of the Association, therefore, who are in doubt about going to Yosemite are urged to scan again the April issue program and, while still under the spell of the attractions noted, to pack their grips, preparatory to joining their fellows in what promises to be a well-attended series of noteworthy meetings.

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

CALIFORNIA'S HEALTH INSURANCE BILL (S. B. 454)

Health Insurance Commission Act (S. B. 454) Introduced on April 12.—The *Senate Daily Journal* of the forty-sixth legislative day (April 12, 1935), contained 197 pages, all but twenty-five of which were given over to a discussion of the need of a proposed law (embodied in Senate Bill 454), providing for "State Health Insurance Service, including the establishing of a Health Insurance Commission and prescribing the powers. . . ." The 172 pages contained a draft of S. B. 454, printing, on pages 38 to 55, some sixteen pages of amendments to the original skeleton bill.[1] Many more amendments will be introduced, no doubt. Mention is made of this to indicate how difficult it is to whip into form a measure such as this, for which so much pioneering must be done in order to make the plan conform both to American legal procedures and also the standards of American civilization and custom.

* * *

An Outline of the Health Insurance Topics Discussed in the Senate Daily Journal.—In turning the pages of the *Senate Daily Journal,* the "Report of the Senate Committee on Investigation of the High Cost of Sickness" is found to contain a large number of items, the nature of which may be judged by the following list:

Page 23: Report to the Senate by the Interim Committee, under date of April 12, 1935.
Page 27: Remarks on "How Can the Legislature Bring Hospital Service within the Reach of Persons of Average Income?"
Page 28: "Facts Found by the California Medical Economic Survey."
Page 34: Remarks on "Economy Security and Health Insurance."
Page 38: Amendments to Senate Bill 454.[2]
Page 55:[3] Appendix A—"Is Health Insurance Coming to California?" Address given by Senator E. H. Tickle at the University of California Western Conference on Government, Thursday, March 28, 1934.
Page 58: Appendix B—"Opening Statement by Senator Edward H. Tickle at Public Hearing of Senate Committee on Investigation of the High Cost of Sickness held Friday, December 14, 1934, State Building, Civic Center, San Francisco, California."
Page 102: Appendix C—Miscellaneous Resolutions by Interim Committee, California Medical Association House of Delegates and other organizations.
Page 105: Appendix D—"California Medical-Economic Survey.[4]

1 Senate Bill 454 was introduced as a "skeleton" bill on January 25, 1935, as follows: "An Act to provide for the establishment and administration of a system of health insurance for persons in certain income groups."

The new title, as amended on April 15, 1935, now reads: "An Act to provide for the establishment and administration of a system of State Health Service Insurance, including the establishing of a Health Service Insurance Commission and prescribing the powers, duties and functions thereof, the establishing of a Health Service Insurance Fund and providing for certain payments thereto, the prescribing of methods and conditions under which professional or other services may be rendered, the regulation of certain persons, firms, associations, and corporations, the making of an appropriation, the enforcement of the provisions hereof, penalties for the violation of the provisions hereof, and repealing acts in conflict herewith."

2 Pages 38 to 55, inclusive, cover Senate Bill 454, as amended and submitted by Senators Williams, Tickle, and Difani.

3 Pages 55 to 195 are appendices, presumably prepared by the Coördinator—Secretary of the Interim Committee, Celestine J. Sullivan, LL.D.

4 This contains selected facts from the report of the survey staff of the Committee of Five of the California Medical Association and the field survey of the California State Board of Health. Twenty-six tables are included in this section.

Page 129: Appendix E—A thirty-eight-page section of figures, diagrams, and charts, based on the California Medical Association Medical-Economic Survey.
Page 167: Appendix F—"Some Compulsory National Plans, Showing Country and Years of Principal Laws."
Page 176: Appendix G—"Anachronistic Attitude of American Medical Association at Chicago."
Page 181: Appendix H (two parts)—Part I: "The Doctor and the State" by Morris Fishbein, M. D., Editor, *Journal of the American Medical Association.* Part II: "Doctors, Patients, and the Community" by William Trufant Foster, LL.D., formerly president of Reed College, and since 1920 Director of the Pollak Foundation for Economic Research.
Page 192: Appendix I—Two Cartoons: One from the San Francisco *News,* the other from the San Francisco *Chronicle.*
Pages 194 to 196: Appendix J—"Condensed List of Publications Consulted."

We have listed the above in order that those readers of CALIFORNIA AND WESTERN MEDICINE who do not have access to the April 12 issue of the *Senate Daily Journal* report referred to may be the better able to visualize the nature of this important communication.

* * *

The Labors of the Committee of Six.—The Committee of Six (Dr. Junius B. Harris, Sacramento; Dr. Fred R. DeLappe, Modesto; Dr. E. T. Remmen, Glendale; Dr. Walter B. Coffey, San Francisco; Dr. T. Henshaw Kelly, San Francisco, and Dr. Joseph Catton, San Francisco), on behalf of the House of Delegates has had an onerous, even though interesting task to perform; and it has earned the generous appreciation of the five thousand members of the California Medical Association. Indeed, the labors of the Committee of Six are not yet ended, for its members must now faithfully study all proposed amendments and make certain that the changes suggested will not depart from the stipulations laid down in Ingber Resolution No. 2.[5]

* * *

A Progress Report Will Be Made at the Yosemite Annual Session.—By the time this year's annual session has convened at Yosemite (on May 13), much more will be known of the course S. B. 454 is taking through both houses of the California Legislature. The Committee of Six and Council will then make a progress report, and this should prove of exceptional interest to all members of the Association.

AN IMPORTANT INDUSTRIAL MEDICAL PRACTICE PROBLEM

The Proposal to Lower the Industrial Accident Fee Table.—In the April number of CALIFORNIA AND WESTERN MEDICINE (pages 273-274), under the caption, "Proposal to Lower State Compensation Fund Fees," comment was made on several resolutions of protest against proposed reductions in the fee table of the California State Industrial Accident Commission.

* * *

Resolutions of the California Medical Association Council.—The attention of members of the Association is again called to several paragraphs contained in the resolutions adopted by the Council of the California Medical Association, and mentioning as follows certain violations of the code of ethics, which had crept into industrial accident work:

WHEREAS, Certain physicians and surgeons, some being members of the California Medical Association, have been guilty of cutting fees below the official fee schedule, and/or have made a practice of underbidding for industrial accident work other members of our profession and/or have been guilty of rebating to the insurance companies; now, therefore, be it

Resolved, By the Council of the California Medical Association:

1. That the Council make strong protest to the Industrial Accident Commission against reduction of fees;
2. That the members of the medical profession be advised of their responsibility in the matter;
3. That the fee schedule be reviewed and adequate arguments for adherence thereto be emphasized; and
4. That the Industrial Accident Commission be requested to adhere to the fee schedule itself in all its departments, and to require recognition of the schedule of insurance companies; and be it further . . .

* * *

Rebates and Discounts Not Known in the Year 1914.—It is interesting to note that when, in the year 1914, the House of Delegates of the Medical Society of the State of California (California Medical Association), approved the fee table which had been worked out in conference with the first California Industrial Accident Commission, the unethical practice which at that time was prohibited had to do only with "contract practice."* In other words, the evil of rebates and discounts, given by individuals or groups of physicians to insurance carriers, was not foreseen or appreciated in that day; receiving, therefore, no mention by the Delegates. However, in the years that have since come and gone, it has become more and more apparent that the discount and rebate practice, of which certain physicians have been guilty, was perhaps the most demoralizing of all the influences that have played a part in the recurrent printed and spoken scandals cropping up, from time to time, in industrial medical practice. That these unethical and unwholesome methods have grown worse, instead of better, is shown by the statements printed some weeks ago in the San Francisco newspapers; wherein, among other things, Manager Day of the State Compensation Fund was quoted as saying that the reason the State Compensation Fund felt that a reduction in the industrial fee table was very necessary, was due to these rebate and discount practices. These enabled certain insurance carriers, other than the State Compensation Fund (an insurance carrier owned and operated by the State of California), to secure competitive business by offering lower rates; such reduced rates being made possible because of rebates and discounts on professional services rendered by the physicians employed by such carriers.

* * *

The Question Before the Medical Profession.—The question, therefore, now before the medical

[5] This resolution was printed on page 187 of the March CALIFORNIA AND WESTERN MEDICINE.

* See Reference Committee report in the minutes of the House of Delegates, as printed in the July, 1914, issue of the *Journal of the Medical Society of the State of California* (former name of CALIFORNIA AND WESTERN MEDICINE).

profession is that of doing away with such unethical and improper rebating and discounting; to further which reform, the California Medical Association, through its Council, has gone on record calling the attention of the component county societies and their members to the need of eradicating the evil.

* * *

A Proposed Amendment to the Industrial Insurance Act.—At a meeting of the California Medical Association Executive Committee, the problem was further discussed, and consideration given to the possibility of securing the adoption of an amendment to the present Industrial Accident Act, whereby a clause, such as that contained in sections 102 and 103 of the proposed Health Insurance Act, and modified to apply to industrial insurance, might be enacted into law. The passage of such an amendment to the existing statutes would go far in eliminating practices that have shed reproach upon the medical profession and which, unchecked, give advantages to so-called "chiselers" who secretly profit at the expense of more honest colleagues. Should the sections referred to, and herewith reprinted, be presented at Sacramento, it may prove interesting to observe from what sources and on what grounds, opposition to their enactment will come:

102. The rendering of services under this Act is a privilege, and any physician or dentist and any regularly established hospital, or laboratory, or any other person or agency able and desiring to render services necessary for the proper furnishing of benefits, shall be entitled to render services in accordance with the provisions of this Act; provided, however, that the Commission, after notice and a full opportunity to be heard pursuant to the provisions of this Act, may, upon determining that good and sufficient cause exists, revoke such privilege. The following shall be deemed to be good and sufficient cause for revocation of the privilege of rendering services under this act: fraud, deceit, intent to defraud, gross neglect, habitual intemperance, habitual use of narcotic drugs, rebate of fees or charges that will result in the actual rendering of services at rates below those for fees or charges that may be established by the Commissions, solicitation of patients, or any violation of the Medical Practice Act or Dental Practice Act of this State; provided that none of the aforementioned causes shall justify the revocation of such privilege unless done or committed while the physician, dentist, hospital, laboratory or other person or agency was rendering services under the provisions of this Act.

103. In addition to its own action against a physician or dentist for any of the causes specified as sufficient for the revocation of the privilege of rendering services under this Act, the Commission shall file a complaint with the State Board of Medical Examiners or the State Board of Dental Examiners, as the case may be, against any physician or dentist found by the Commission to be guilty of any of the acts specified in the State Medical Practice Act or State Dental Practice Act as cause for revocation of license.

WHERE SHALL LICENSURE OF SPECIALISTS BE CENTRALIZED?

Multitudinous Functions of the State Board of Health.—The sanitary and other codes of California are spotted with public health laws and legislation in which physicians have a natural interest. At each monthly meeting of the State Board of Health, that body is required to take action on a docket of public health problems that is little less than appalling. Each succeeding legislative session, with its additions of new laws, specifies new duties for the department and its board members.* It may be proper to mention one of the recent problems having to do with the granting of licenses in laboratory specialties, and passed up to the State Board of Public Health.

* * *

Shall the State Board of Health License Specialists?—Several proposed laws now before the legislature deal with licensure of general and x-ray laboratories by the State Board of Health, and the granting of certificates or licenses to physicians and others who have been found to be qualified to conduct the same. At the April 13 meeting of the Executive Committee of the California Medical Association, the point was raised that all forms of licensure relative to medical practice should be vested in and be retained by the California State Board of Medical Examiners. To confer some of the licensure authority on the State Board of Health would only result in undesirable duplication and confusion. With this principle, the members of the State Board of Health, by resolution, are in full accord; and in view of its attitude, it is to be hoped that all who, in the future, sponsor legislation providing for the licensure of persons having to do with phases of medical practice, will place such authority with the California State Board of Medical Examiners, where it properly belongs. Otherwise a non-licensure board would practically be given authority to create types of medical and other specialists, a function which, in one sense, is only indirectly related to the public health, and which neither the State Board of Health welcomes, nor physicians-at-large approve.

THE LEGISLATIVE MILL

Massive Amount of Proposed Legislation.—The perusal of reports of the proceedings in the Senate and Assembly chambers at Sacramento, as given in the newspapers, must make all citizens realize what a massive and confusing amount of general and special legislation has been submitted since January 3. In previous issues of the JOURNAL, lists of measures having a relation to public health and medical matters have been printed, with specific comment on some of the proposed laws.

* * *

The Proposed Health Insurance Law: S. B. 454.—On April 12, the proposed health insurance law, the advent of which was long awaited by members of the profession and many lay citizens—not only in California, but in other states of the Union as well—made its appearance, as Senate Bill 454, under the sponsorship of Senators Williams, Difani and Tickle (the Interim Committee). The measure is commented upon elsewhere,[1] and before this May number of CALIFORNIA AND WEST-

* An article, on page 337 of this issue, by Dr. Howard Morrow, president of the State Board of Health, mentions some of the standing activities and responsibilities of the State Department of Public Health.

[1] Comments in this issue are printed on pages 388, 395, and 405.

ERN MEDICINE reaches its readers, all members of the California Medical Association will have received, from the office of the Association, a special letter and other printed information concerning the bill.[2] Every member is, therefore, urged to read the same, and to feel free to send to the Association Secretary such comments, suggestions or criticisms as may seem pertinent, and of which the Committee of Six will be glad to avail itself. In the attempt to formulate a law of such tremendous importance to medical practice, and which represents such a pioneering advance, with no precedent in American legislation by which to be guided, it is necessary that every word and line of the newly written statute shall be most carefully considered and appraised, lest errors creep in, which, by later court decisions (should the law be enacted), would nullify the stipulations laid down by the House of Delegates at the special session held at Los Angeles on March 2 and 3, when it gave its instructions to the Committee of Six. Members owe it to themselves, in view of their own personal interests, and also to organized medicine, as represented by the California Medical Association, not only to read the bill but to carefully study it, and to fully discuss it with fellow physicians. Such discussions should be supplemented by written communications on its merits and demerits sent in to the central office of the Association, in care of the Committee of Six or the secretary. And this, because every physician, both as a medical practitioner and as a citizen, has a right to be heard; the present time, being the best for giving expressions to opinions, whether for or against, before the bill is enacted into law.

* * *

Comment on Other Proposed Legislation.— A. B. 1552, providing for a qualifying certificate act, is still in committee, having received many amendments from various sources. There is a growing sentiment that this bill, if it were to become a law through passage by the legislature, would fail to be of broadest use. For that reason, it may die in committee, thus permitting its consideration as an initiative measure at a future State election. Members who are interested in the measure should write to the State Printer at Sacramento, making request for a copy. Suggestions or criticism should be sent to the chairman of the special committee, whose report appears in the "Pre-Convention Bulletin," printed on page 317 of the April issue.

A. B. 2041, the dog pound (antivivisection) bill, is following the routine course of readings in committee. We have not learned whether its sponsor, Assemblyman Charles J. Wagner of Alameda, whose occupation in the Assembly roster is given as business manager of the Butchers' Union, will be as aggressive in its support as was former Senator Fellom, who espoused the measure in the legislative session of two years ago. Time will tell.

2 Copies of the booklet, containing a copy of the S. B. 454, sold at one dollar each, may be secured by non-members upon application to the Association Secretary at Suite 2004, Four Fifty Sutter Building, San Francisco.

EDITORIAL COMMENT*

THE SEXUAL FACTOR IN PROSTATIC HYPERTROPHY

While the technique for the surgical removal or transurethral management of the hypertrophied prostate has reached a high degree of perfection, little advance has been made in recognizing the cause of this disease or the means of preventing it. Kenneth Walker's [1] survey indicates that prostatic enlargement is less common among the inhabitants of Japan, China, India, Philippines, and other parts of Africa, and among the negroes in North America. As a result of his rather extensive study, Walker believes that prostatic enlargement has an anthropological distribution and, according to frequency, he classes the races in the following order: Caucasian, Semitic, Arabic, Indian, Mongolian, and Negroid. Those countries in which prostatic enlargement is rare are the very places in which the sexual life is rather unrestricted.

What, then, is there about the sexual life of the Caucasian which predisposes him to prostatic hypertrophy? Is this form of tumor the price he pays for so-called "higher morality"? Why then should the celibate clergy escape it? Why should married men be particularly subject to it? *What is the relation between the sexual life and prostatic overgrowth?*

The statistics of hospitals, clinics, etc., conclusively show that the indiscretions of youth bear no definite relationship to the formation of prostatic tumor. On the other hand, every urologist knows that if a man leads a normal sexual life and then suddenly ceases to have indulgence, his prostate will become congested, frequently giving rise to urinary disorders; in such cases we find on rectal examination a large, tender prostate; on massaging such a prostate, we can usually express a copious quantity of prostatic secretion, together with the products of inflammation. Such an artificial evacuation is attended with relief of the symptoms and reduction in size of the gland. Ballenger, Elder, and McDonald [2] have reported a very significant observation in the matter of preventing benign enlargement of the prostate; among their patients who were periodically massaged there occurred no cases of prostatic hypertrophy. They reason that a mild irritating toxin produces the hyperplasia, and that by massage this toxin is eliminated. Von Lackum and Mitchell [3] were able to obtain excellent results in the so-called bar obstructions by routine massage, instillation, and dilatation.

* This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Walker, K., *The Nature and Cause of Old Age Enlargement of the Prostate,* 1922.

2 Ballenger, Elder, and McDonald, Urol. and Cutan. Rev., No. 6, 1930.

3 Von Lackum and Mitchell, J. Urol., 22:57, 1929.

Prostates become disordered during the period of the male "sexual crisis," unless they are relieved of their contents either in a physiological or mechanical manner. When there is a sudden abatement of sexual activity the prostate becomes congested and swells because there is an accumulation of secretion which gives rise to so-called "prostatic trouble." It is a well-known fact that a considerable number of men entering the middle span of life radically alter their sexual conduct, some of them because they feel that celibacy constitutes the ideal life, others because they think that by foregoing sexual activity they will conserve their energy, resistance to sickness, and thus prolong their longevity. On many men continence is forced by their spouses being ill or "frigid," or because their sexual desire is inhibited by financial or business worries which are so much in vogue these days. All such cases are very apt to inflammation, or "swelling," or "congestion" of the prostate, and this condition is associated with urinary symptoms. Unless their prostates are depleted by massage or an equivalent measure, this gland will continue gradually to enlarge and provoke "prostatismus."

The celibate clergy are, according to Hugh Young,[4] practically immune to prostatic hypertrophy and, consequently, to symptoms of "prostatismus." In this group the prostate never develops into an actively secreting gland because at a very early age the sexual life was abnegated, and the prostate, accordingly, was never called into activity as it is in the normal married man. Celibacy adopted late in life is, therefore, not a preventive, but rather an accelerative factor of prostatic enlargement.

How to explain the frequency of prostatic hypertrophy among the Caucasian race as compared with other races? The main cause of this difference is our cultural code with its tendency to repress the natural outlet of sexual energy. Prostatic congestion is the price often paid for it. Therefore it seems that the logical method of preventing prostatic hypertrophy is periodic massage of the congested prostate, or such a sexual life that is compatible with the age, inclination, and general welfare of the patient.

1025 Story Building.

S. I. Movitt,
Los Angeles.

4 Young, Hugh, *Practice of Urology*, Philadelphia, 1925, Saunders Co.

THE HYPOPHYSIS AND URINE FORMATION

Since the experiments of Magnus and Schaefer in 1901 it has been known that extracts of the pituitary gland affect the rate of urine formation by the kidney. The experiments of Motzfeld[1] and of Rees[2] definitely established the fact that, while extracts of the posterior lobe of the hypophysis may cause a temporary diuresis, the principal effect is one of diminution in urinary flow. Stehle and Bourne[3] became interested in the changes in salt excretion, and showed a considerable increase in output of potassium and chlorid during the early period of diuresis; but they did not study the later and more prolonged period of antidiuresis. New light on the renal effects of pituitary extracts came from the recent experiments of Nelson,[4] who showed that subcutaneous injections of the posterior lobe extracts in minimal effective dose have a pure antidiuretic effect, but that, in spite of the decrease in urine volume, there is an absolute increase in the excretion of chlorid.

With increasing doses of pituitary extract, up to an optimal range, there was a decrease in the urine volume. Above this optimal dose the urine volume increased again up to normal. The explanation for this paradox lay in the fact that, with increasing dose of pituitary extract, the salt concentration of the urine rose to a high point. The high concentration of salt leads to a high osmotic force in the kidney tubule, and this prevents the reabsorption of fluid from the tubule by the renal epithelium. These experiments of Nelson have been amply confirmed by Engel, McQuarrie and Ziegler,[5] and Marx.[6]

Thus, there are apparently two opposing mechanisms involved in the diuretic-antidiuretic action of posterior lobe pituitary extracts. The one, an increased excretion of salt, the other, a decreased excretion of water. We still do not know how the excretion of salt is increased or the excretion of water decreased.

Department of Pharmacology,
School of Medicine, University of Southern California.

C. H. Thienes,
Los Angeles.

1 Motzfeldt, K.: J. Exper. Med., 25:153, 1917.

2 Rees, M. H.: Am. J. Physiol., 45:4, 1918.

3 Stehle, R. L., and Bourne, W.: J. Physiol., 60:229, 1925.

4 Nelson, E. E., and Woods, G. G.: J. Pharmacol. & Exper. Therap., 50:241, 1934.

5 Engel, R., McQuarrie, I., and Ziegler, M.: Arch. f. Exper. Path. u. Pharmakol., 173:248, 1933.

6 Marx, H.: Arch. f. Exper. Path. u. Pharmakol., 173:526, 1933.

The Age Limit for Professors. — The present age limit for professors of the imperial universities was first established in 1918 in the Tokyo Imperial University on the motion of professors of the medical department. Since then the question has been raised whether it is proper or unreasonable, but it has been faithfully obeyed as an unwritten law though it was merely a gentlemen's agreement. Sixty years, some think, is too early to retire. Professor Dr. K. Manabe, who has been about a year in Europe and America, has written on this subject in the *Varsity Press*, saying that the age limit should be abolished, as the age limit in Italy is 75, in Greece and France 70, in Germany from 65 to 68, and in Switzerland 70 years. Some are of the opinion that the age of 60 is the time when man is intellectually in his prime. It is absurd to apply the age limit uniformly without considering some personal factors. This law is now enforced only in the government universities, with one exception. If there is any good reason for this law, it ought to be enforced among other colleges. Some who have retired under this system have soon after been appointed to important offices. That there are many positions open to the retired professors better than the old post shows that it is not a disgrace to retire at 60; on the other hand, the present plan permits energetic young scholars to find their way to a professorship.—Japan News Letter.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

CLARENCE G. TOLAND.....President
ROBERT A. PEERS.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

STATE AND COUNTY SOCIETY ACTIVITIES

SERA MEDICAL PROGRAM

After several months of conferences, disappointments and delays, it has been at last possible to perfect an SERA program for medical care for those on relief. On March 27 the following bulletin was sent out. It is hoped that county societies will expedite their local arrangements.

CALIFORNIA MEDICAL ASSOCIATION

Important Instructions

March 27, 1935.

To Officers, Councilors, and County Secretaries:

1. I am delighted to be able to at last announce a definite plan for providing medical care for persons on SERA relief. This has been approved by Mr. McLaughlin, the State Administrator.

2. In my conference with Mr. McLaughlin on March 22, the following agreement was executed:

(*a*) The State Commission will appoint two of its members who will join with two members appointed by the California Medical Association to form a medical advisory commission. This advisory committee will serve to aid and direct a State program for medical care, and will serve in an advisory capacity to Mr. McLaughlin and the State Medical Director.

(*b*) A State Medical Director will be appointed. The medical director will supervise and approve plans for county medical relief.

(*c*) County medical societies are to appoint a local committee of three, who will advise and work with the County Relief Administrator.

(*d*) Mr. McLaughlin will send out in a few days a bulletin to all county administrators, directing them to comply with these instructions.

(*e*) FERA Bulletin No. 7 will be used as a general guide in establishing certain forms of county medical relief plans.

(*f*) The following fees have been agreed upon:

Office calls	$1.25
House visits	1.75

3. Your county society should immediately record the following action:

(*a*) Appoint a local committee of three to advise with your county administrator.

(*b*) This committee should be prompt to arrange for a conference with your county administrator and perfect your local arrangements and secure approval and inauguration of your plan.

4. This communication and the bulletins of Mr. McLaughlin should be used in securing prompt action on the part of your county administrator.

Please report whatever action is agreed upon in your county.

Sincerely,

F. C. WARNSHUIS, M. D.,
Secretary.

* * *

April 24.—The Medical Advisory Committee is working in close coöperation with the SERA Administrator. At a conference today the State Administrator stated that he had sent out an order to county adminisrators that their county medical plan must be submitted by May 1. That in formulating a county plan the County Administrator must consult with and come to an agreement with the representatives of the County Medical Society.

County societies should press their work, complete their plans, secure approval in order that medical services be made available and doctors obtain remuneration for their services.

* * *

RÉSUMÉ OF EXECUTIVE COMMITTEE MEETING, APRIL 13, 1935

The Executive Committee of the Council met in San Francisco April 13, 1935. All the members were present.

Details relating to the annual meeting were reported on and discussed. On April 10 there were 916 confirmed hotel reservations.

The Secretary was instructed to arrange for the medical exhibit at the San Diego Fair.

The Executive Committee, following mail vote of the Council, provided additional funds to complete the work of the Committee of Five.

The committee approved the appointment of Drs. Morton Gibbons, Sr., and Harry Wilson to represent the Association on the SERA Medical Advisory Committee.

An invitation was received from the American Medical Association to send a representative to a Medico-Economic Conference in Chicago on April 27. Several nominations were made, and the Secretary was directed to arrange for one of these nominees to attend as California's representative.

A lengthy presentation of legislative matters was discussed and recommendations were made to the Legislative Committee.

Adjourned at 3 p. m.

F. C. WARNSHUIS, *Secretary.*

* * *

YOUR FELLOW MEMBERS SERVE YOU

Over a considerable number of years we have wondered time and time again whether members recognized and appreciated the contributions and services that fellow members rendered to fellow members. Your executive and administrative officers have long since learned that in emergencies or when special activities required action that then, in response to a call, designated members would respond. These men would cancel their engagements, leave their homes and sacrifice their time and personal interests to serve their fellow members. During the past six weeks we have witnessed an outstanding instance of such service.

At the special meeting on March 2 and 3, our Association committed itself to a definite policy related to health insurance. By resolution the House of Delegates delegated the drafting and application of that policy and the safeguarding of professional interests to a special committee, composed of six fellow members. It is to that committee at this time that a very genuine and sincere expression of appreciation and thanks is tendered.

Six fellow members, appointed by Speaker Pallette, recognized their responsibility and the need for prompt action. They canceled all their engagements and devoted themselves to the task of carrying out their instructions and complying with the desires of their fellow members. Meetings!—would we could describe

them. Sessions—not one, but more than twenty, commencing at 9 a. m. and often lasting till the wee hours of the morning. One morning one member was seen leaving an all-night session at eight o'clock, tired and hollow-eyed. It is men such as he and his co-laborers who have made American medicine and the California Medical Association.

Such services are assurance to all members that their professional and personal interests, now and for the future, are being safeguarded and enhanced by fellow members who serve you on committees, Council, and in office. That is why membership should be highly prized.

To this committee, at this time, do we offer our expressions of deep appreciation: Doctors T. Henshaw Kelly, Walter B. Coffey, Junius B. Harris, E. T. Remmen, Fred R. DeLappe, and Joseph Catton.

The Advisory Committee, composed of Doctors Clarence G. Toland, A. J. Scott, Edward M. Pallette, Henry Dietrich, Los Angeles; Rodney A. Yoell, LeRoy Brooks, Irving S. Ingber, Loren R. Chandler, Langley Porter, San Francisco; Victor W. Hart, Yreka; Lemuel P. Adams, Oakland; W. W. Roblee, Riverside; Louis A. Packard, Bakersfield; Robert A. Peers, Colfax; Dewey Powell, Stockton; Lyell C. Kinney, San Diego, likewise merit hearty thanks for their time and services. To Professor John B. Canning the Association is indebted for his time, interest and helpful advice. Mr. Hartley F. Peart, our legal counsel, was indefatigable in his assistance. Our thanks is but little reward, still it does record our sentiments.

* * *

OFFICIAL CALL, AMERICAN MEDICAL ASSOCIATION ANNUAL SESSION

To the Officers, Fellows, and Members of the American Medical Association:

The eighty-sixth annual session of the American Medical Association will be held in Atlantic City, New Jersey, from Monday, June 10 to Friday, June 14, 1935.

The House of Delegates will convene on Monday, June 10.

The Scientific Assembly of the Association will open with the general meeting held on Tuesday, June 11, at 8:30 p. m.

The various sections of the Scientific Assembly will meet Wednesday, June 12, at 9 a. m. and at 2 p. m., and subsequently according to their respective programs.

Walter L. Bierring, *President.*
Frederick C. Warnshuis,
Speaker, House of Delegates.

Attest:

Olin West, *Secretary.*
Chicago, Illinois, March 25.

* * *

CALIFORNIA HOSPITALS

The March 30 number of the *Journal of the American Medical Association* contains the annual hospital report. The data on hospitals are the most complete, accurate and up to date that have ever been assembled in any publication.

Recently certain persons broadcast through the public press that 1,300 counties in the country, with a population of 18,000,000, have no hospitals and that these people were deprived of hospital services. This hospital number refutes that statement.

California has 382 hospitals. Of this number, 239 are general and they reported 63.4 per cent occupancy. The general hospitals have 29,550 beds and admitted 403,583 patients. There are forty-one nervous and mental hospitals, with 25,085 beds and 23,505 patients. Tuberculosis hospitals number forty-two, with 4,520 beds and with 3,872 resident patients. There are nine maternity hospitals with 338 beds that admitted 1,311 patients, and an average daily census of 249. Industrial hospitals number 10, with 721 beds; and two eye, ear, nose, and throat hospitals, with 50 beds. There are 3 children's hospitals, 2 orthopedic, 116 isolation, 13 convalescent, 12 institutional, and 7 miscellaneous.

These 382 hospitals provide 63,149 beds and 3,075 bassinets. They admitted, in 1934, some 454,070 patients, and had a daily census of 48,851 patients.

These hospitals had 231 clinical laboratories, and 262 x-ray departments. Superintendents are classified as 120 physicians, 136 registered nurses, and 125 laymen.

The foregoing are but a few of the interesting facts in this report. The entire report is well worth studying.

* * *

DISTINGUISHED BRITISH GUESTS

On August 4, a party of some two hundred physicians and surgeons, members of the British Medical Association, and the association's secretary will land in New York. They will travel across the country and arrive in Los Angeles August 12. They leave Los Angeles the morning of August 13 and arrive in San Francisco that evening. They sail from San Francisco the afternoon of August 14 for Australia, where the 1935 annual meeting of the British Medical Association will be held.

* * *

SERA MEDICAL ADVISORY COMMITTEE

State Administrator Frank Y. McLaughlin on April 15 appointed Mr. Edward H. Heller and Mrs. Earl F. Treadwell as his representatives upon the Medical Advisory Committee. These appointees, with Dr. Morton R. Gibbons and Dr. Harry H. Wilson, compose the committee that will inaugurate a State medical program for those on relief.

County societies, through a committee, are urged to contact their county administrator and adopt a plan of medical service. Prompt action is desired.

* * *

AMERICAN MEDICAL ASSOCIATION FELLOWSHIP

In a report as of December 31, 1934, it is shown that there are 10,490 licensed physicians in California. Of this number, 3,260 are Fellows of the American Medical Association, and 2,042 are subscribers to the *Journal of the American Medical Association.*

Possibly 75 per cent of these 2,042 subscribers are eligible to Fellowship. They can become Fellows at no additional cost; simply write in for an application blank.

Every one of our some 6,000 members should become a Fellow of the American Medical Association for obvious reasons. The same procedure governs. Send in for an application blank.

* * *

CORPORATIONS ARE DENIED ANY RIGHT TO PRACTICE MEDICINE

Judge Michael L. McKinley of the Superior Court on March 22 decided the *quo warranto* case of Attorney-General Kerner against United Medical Service, Inc., brought to determine whether a corporation may practice medicine. Judge McKinley held that a corporation is not permitted to practice medicine in this State. Harry Eugene Kelly represented the Attorney-General as special counsel. Judge McKinley found that the United Medical Service, Inc., was usurping the liberty, privileges and franchise of engaging in the diagnosis and treatment of diseases of human beings, contrary to the Medical Practice Act, and that judgment should be entered ousting that corporation from the franchise, occupation, and business of "holding itself out to the public as being engaged in the diagnosis or treatment of ailments of human beings, and from suggesting, recommending or prescribing any form of treatment for the palliation, relief, or cure of physical or mental ailments of persons, with the intention of receiving therefor either directly or indirectly any fee, or compensation, and from diagnosticating, or attempting to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat, any ailment, or supposed ailment, of another, and from maintaining an office for the examination or treatment of persons afflicted or alleged or supposed to be afflicted, by any ailment; and from usurping, intruding itself into, or unlawfully holding or executing any such franchise, occupation, or business, either by or through the services of physicians and surgeons duly licensed and registered under the Medical Practice Act, and employed and paid by the respondent, or otherwise."

The foregoing report is from the *Chicago Medical Society Bulletin,* and is concerned with a Chicago corporation.

ADVERTISERS

Our members' attention is directed to our advertising pages. Turn to them. There are several new "ads" appearing in this issue. All our advertisers merit patronage, for they make your publication possible. Without this income your dues would have to be increased $4 per year. Everything else being equal, please give preference to your advertisers when placing your orders.

* * *

SICKNESS INSURANCE AND SICKNESS COSTS*

"Today 1,250,000 persons are employed full time in the care of the sick. Of these, some 150,000 are physicians and 60,000 are dentists. The vast majority are nurses, pharmacists, dietitians, record clerks, and all the assorted personnel of the hospital and medical staffs. . . .

"The control of the care of the sick must be kept in the hands of the doctors and dentists, who are the only ones properly qualified to do this by education, experience, and legal licensure. . . .

"The medical and dental professions cannot be forced into insurance plans. They must work out these plans for themselves on the basis of the needs of the situation. . . .

"There are approximately 250 lay-dominated foundations in the United States, of which about 170 have as their major interest the control of medical care. The leading groups include the Rosenwald Fund, the International Health Board, the Twentieth Century Fund, and the Millbank Fund. . . .

"When President Roosevelt was elected he stated that his first consideration would be problems of recovery and relief. Apparently, when he left for his trip to Hawaii he decided that actual security control would be his next step, for he announced on his return that he was ready to attack the problem of greater economic security for the American people.

"He appointed a committee of four members of his cabinet—Secretaries Perkins, Cummings, Wallace, and Morgenthau—and in addition, Harry Hopkins, relief administrator. They selected E. E. Witte as head of a technical advisory staff. In turn, thirteen subadvisory staffs were appointed, that for medicine being headed by Edgar Sydenstricker of the Millbank Fund. Sydenstricker soon associated with himself as advisors, Michael Davis of the Rosenwald Foundation, Nathan Sinai of the Twentieth Century Fund, and Isidore Falk of the Millbank Fund.

"Eventually, when protests were made against this type of control over the proposals to be made for medicine and a request made for a medical advisory board, Drs. R. G. Leland and A. M. Simons of the American Medical Association Bureau of Medical Economics were added to this group. . . .

"The American Medical Association and the American Dental Association favor controlled experimental investigation in the problems of providing care to all the people of the United States in the same way that they demand scientific study before embarking on any routine system of medical or dental care. Such experiments, in order to be proper experiments, shall naturally have to be under the direction of physicians and dentists."

* * *

OUR CHANGING TIMES†

"The advancement of preventive medicine and the increased control of disease are hampered in every community by the fanatical cultist who opposes every type of medical investigation and development in public health. He is a menace to further control over the death rate from diphtheria, control of the spread of smallpox and of infantile paralysis, measles, and similar diseases, and even to investigations carried on in scientific laboratories." . . .

"It is impossible in the time available to give a complete picture of sickness insurance abroad. Nevertheless, I can say that there has not yet been developed in any foreign nation a system of sickness care satisfactory to both the people and the physicians in the community where the system exists.

"One can mention particularly that the British system last year, with an income of $41,000,000, had administrative expenses of $23,000,000, and that the British system is not satisfactory since it cares only for the occasional illness that can be treated by the doctor in his home or office. Surgical operations and obstetrical cases, which are the chief problems of the American people, are not considered in the British system. It does not cover the worker's family, but only the worker himself.

"The German system is in a state of chaos due to the revolution brought about by the Nazi Government. The average German workman, who today receives a wage of 30 marks per week, finds that 11 marks are deducted at the source for all types of insurance, care of the crippled, aged, mentally diseased, a state tax, and similar demands, leaving him only 19 marks of his weekly wage for personal use.

"The French system is also in a chaotic state, and in three instances the medical profession has gone on strike against health insurance. Three hundred physicians under the state system carry for themselves voluntary sickness insurance in voluntary companies.

"In Great Britain, moreover, some eight thousand physicians have formed an insurance union and allied themselves with the Federation of Labor in order to protect themselves from the state's invasion into medical practice.

"Finally, neither the French, German, nor English systems of economic care have accomplished for those countries a lowering of morbidity rates to a point equal to those of the United States at the present time.

"Tuberculosis is particularly an index of the work of preventive and medical care, and the tuberculosis morbidity rates today are lower in the United States than in any of the countries in which compulsory sickness insurance exists.

"So far as dental care is concerned, the quality of the teeth of the average American is definitely superior to that of the so-called 'best people' abroad." . . .

"The creation of a compulsory sickness insurance system in any state involves the development of a vast bureau which may easily evolve into a political machine.

"Any group considering compulsory systems should find out whether or not the bureau to be developed will employ such a large personnel as to indicate the building of a new type of political machine, and, furthermore, whether or not the bureau for sickness insurance will involve more money spent by the state than for any other single interest."

"People may still have the kind of medical care they had in 1895 and for the price they paid for such care in 1895. But medical science has advanced more since 1895 than in all the previous centuries. The new type of medical care naturally costs more than the old type did, for it is worth more." . . .

"When you eat more intelligently, you improve your health, and naturally you pay more for an adequate and varied diet." . . .

"The medical budget in the United States has never risen proportionally to the money expended in other fields (even for materials that were not available in 1895). There has been particularly an increased expenditure for cosmetics, tobacco, automobiles and automotive parts, movies, soda water, radios, confections, musical instruments, and so on—all of which represents a part of the increasing of America's desires and wants." . . .

"Investigations indicate that 70 per cent of the people who call on a dentist come to him for relief of pain.

"When people are educated to the importance of dentistry they will come to the dentist for inspection of their teeth and for prophylaxis, so as to prevent the appearance of pain. This does not mean, however, that the State will be bound to provide for such prophylactic inspection of the teeth.

"When the public is sufficiently educated to the value of this service in comparison to the value of other things for which they spend their money, they themselves will provide for the right type of prophylactic care."

"Propaganda is being used to allay social unrest by offering paternal care as a panacea." . . .

"The charlatan of 1900 spoke from the back of his wagon to his little audience.

"The charlatan of 1935, whether political or medical, may speak at one time to twenty millions of people and sway them by slogans and by promises of Utopias that can never be realized." . . .

"Much of the current demand for cheap or free medical care in this country is the result of the continuous fight which has been waged for the past fifteen years by philanthropic foundations, communistic, socialistic, and similar groups."

* Excerpts from Dr. Morris Fishbein's lecture before the California State Dental Association, April 8, 1935.

† Excerpts from Dr. Morris Fishbein's lecture before the Oakland Forum, April 9, 1935.

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on March 21 at Eureka Inn for a 6:30 dinner, with President Charles C. Falk, Jr., in the chair. Eighteen members were present, and two guests, Dr. Howard C. Naffziger and Dr. O. W. Jones, Jr., of San Francisco.

Dr. O. R. Myers was appointed to organize a bowling team to accept a challenge from the Dental Association.

Dr. O. W. Jones, Jr., spoke on *Acute Head Injuries,* and Dr. Howard C. Naffziger on *Primary Hypertension.* These papers were very well received, the members staying until a late hour for further discussion.

LAWRENCE A. WING, *Secretary.*

KERN COUNTY

At the last meeting of the Association the following resolutions on proposed reductions in the fee table for industrial accident work were passed:

WHEREAS, We are advised that the State Compensation Insurance Fund has applied for a hearing before the Industrial Accident Commission for a reduction of 25 to 50 per cent in the fee schedule for professional services rendered industrial accident patients; and

WHEREAS, The fee schedule for professional services is already much below that for similar work in private practice; being, in fact, so low that the fees granted are really less than they should be when all the responsibilities of the Fund, the workers, and the physicians are honestly taken into account; and

WHEREAS, For the Fund to lower its fee schedule still more would work a gross injustice to physicians, who as a class and as individuals are also workers, and who as a class give gratuitous service, which if translated into money values far exceeds that given by any other group to the care of indigent citizens; and

WHEREAS, Actuarial records increasingly show with passing years that the best investment for the economic administration of an insurance carrier (and that includes the State Fund) is a personnel on the industrial panel of the ablest type of physicians; since through their services there are fewer temporary and permanent disabilities; and

WHEREAS, The organized medical profession of the State as represented by the California Medical Association and its component county societies, is opposed to such a reduction of fees; because, so to do will be to the injury of the working men and women of California who come under the jurisdiction of the Workmen's Compensation Act, and be to the detriment and disadvantage of the State Treasury and to the State Fund, and would work a gross injustice upon the members of the medical profession, through whose efficient services much of the past success of the State Compensation Insurance Fund has been due; now, therefore, be it

Resolved, That on behalf of the organized medical profession of California, the Kern County Medical Society herewith respectfully requests the Industrial Accident Commission to take no such action as had been proposed by the State Compensation Insurance Fund; and be it further

Resolved, That copies of these resolutions be sent to His Excellency, Governor Frank Merriam, to each of the Fund commissioners, to the manager of the Fund, to the California Medical Association, to the Los Angeles County Medical Association, and to the official publication of the California Medical Association.

L. H. FOX, *Secretary.*

LOS ANGELES COUNTY

The scientific program of the meeting of the Los Angeles County Medical Association, held in the auditorium of the Association's building on April 4, was arranged by the Pediatric Section.

The subjects discussed were: *The Interdependence of Pediatrics and Orthodontics* by James David McCoy, D. D. S., associate professor of orthodontic surgery, and *Pneumonia of Children* by Earl E. Moody, M. D.

At this meeting honor was paid to past secretaries of the Los Angeles County Medical Association.

The Association, in appreciation of the many years of untiring work that carried with it a large responsibility of stewardship of the Association's multitudinous affairs, presented to the three members who had officiated as secretary during the last twenty-five years (Doctors George H. Kress, secretary from 1909 to 1919; Harlan Shoemaker, secretary from 1919 to 1931; and Harry H. Wilson, secretary from 1931 to 1934) engrossed scrolls carrying the following resolutions:

THIS SCROLL

As a token of appreciation and esteem for his services as secretary-treasurer. His untiring devotion and unselfish efforts in behalf of the Association, splendid leadership and a fine sense of justice, have resulted in a most successful administration. Given this the twenty-ninth day of March, Anno Domini 1935.

With these scrolls there were presented to Dr. Harlan Shoemaker and to Dr. Harry H. Wilson, watches bearing the inscription, "From their colleagues of the Los Angeles County Medical Association."

Dr. George H. Kress, in appreciation of his services as secretary during the years of 1909 to 1919, was presented with a watch by the Board of Councilors at the annual meeting of councilors in December, 1918.

The presentation speeches to Doctors Kress, Shoemaker, and Wilson were made by Dr. Clarence Toland, president of the California Medical Association, who in gracious manner spoke of the special services which had been rendered the Association and its members by the three recipients, who were the honored guests of the evening.

Past-president badges of the Association were also given to three recent presidents: Dr. William R. Molony, president for the year 1932; Dr. Charles T. Sturgeon, president for the year 1933; and Dr. Philip Stephens, president for the year 1934.

These special ceremonies were the more happy in that each of these former officers of the Association had played a real part in bringing into actual realization the headquarters building and the library in which the present-day members are finding such pleasure and value.

E. VINCENT ASKEY, *Secretary.*

MARIN COUNTY

The Marin County Medical Society held its regular monthly meeting on Thursday evening, March 28, at the Marin Golf and Country Club.

A most interesting discussion on *Some Osseous Signs of Malnutrition and Methods of Prevention* was given by the guest speaker, Dr. C. Ulysses Moore of Portland, Oregon. The talk was illustrated very cleverly by lantern slides and moving-picture reels.

Dr. Henry Rogers of Petaluma was also a guest of the evening, and gave a short informal talk on matters of medical organization.

CARL W. CLARK, *Secretary.*

MONTEREY COUNTY

The regular meeting of the Monterey County Medical Society was held at the San Lucia Inn in Salinas on April 5. After the dinner a business meeting was held. The application for membership of Dr. Elliot Rouff was read, and he was voted into membership. A letter was read from the Stanislaus County Medical Society regarding maintaining the x-ray fee schedule, and it was voted to instruct our delegate to the Yosemite meeting to support their bill. It was also moved that President Davlin appoint a committee of three to meet with the local SERA administrator regarding medical care for those on relief.

The scientific part of the program was given by Dr. John Merrill of Monterey, who presented a well-prepared paper on *Idiopathic Hypertension.* Doctor Merrill took up first the medical side of the subject, including in his remarks the x-ray and diathermy radiations over the adrenals, and then discussed the newer surgical procedures, especially those as related directly to the adrenals. A very interesting round-table discussion followed.

WILLIAM H. LAWLER, *Secretary.*

ORANGE COUNTY

The regular meeting of the Orange County Medical Association was held at eight o'clock in the chapel of the Orange County Hospital, Doctor Dawes presiding.

The guest speaker of the evening was Dr. Charles Sturgeon of Los Angeles, who spoke on *Pulsion Diverticulae of the Esophagus*. He reported on his series of twenty-five cases, methods of diagnosis, and the surgical technique. His talk was extremely interesting and was very well received by those present.

Doctor Tedstrom reported for the Constitution Committee, and noted several new changes in the proposed new constitution.

The SERA matter was brought up and, after general discussion, Dr. Russell Johnson moved that the Society appoint a committee of three members, to report within one week to the Board of Managers as to what should be done in regard to the SERA schedule; also that the Board of Managers be empowered to act for the Association. This was unanimously carried.

Dr. John Ball reported for the Industrial Accident Committee. The following motion was unanimously carried: Moved that the Orange County Medical Association approve and adopt the resolutions of the Los Angeles County Medical Association Council protesting the proposed cut of the industrial accident fee schedule and that this resolution be sent to Governor Merriam, Mr. Day, the Industrial Accident Commission, and to Dr. Junius B. Harris, urging that the medical department of the State Fund be preserved.

Doctor Maroon reported that the Medical Collection Committee was making progress. He also announced the program for the Tri-County Conference.

The first reading of Dr. Milton Counter's application for membership was heard.

Doctor Sutherland announced the clinic for crippled children to be held at the Ebell Club House on April 20. It was suggested that the medical association hold its own clinic once a year in connection with the State Health Department.

Waldo S. Wehrly, *Secretary.*

PLACER COUNTY

The Placer County Medical Society held its March meeting at the Freeman Hotel in Auburn on Sunday evening, the 17th, with Dr. Louis E. Jones presiding. In addition to the president, there were present the following members and visitors: Members—Doctors Paul Barnes, Dunievitz, Atkinson, C. C. Briner, Vinks, Empey, Mackay, Eveleth, Lewis, Kindopp, and Peers. Visitors—Dr. C. G. Toland of Los Angeles, president of the California Medical Association; Dr. Frederick C. Warnshuis, Secretary of the California Medical Association; Dr. Junius B. Harris of Sacramento, chairman of the Committee on Public Policy and Legislation; and Dr. E. E. Lundegaard of Weimar.

The applications for membership of Dr. Vernon W. Padgett of Alleghany and Dr. Ellert E. Lundegaard of Weimar were read for the second time and, on motion duly made and seconded, they were unanimously elected.

The application for transfer of the membership of Dr. Paul S. Phelps of Colfax, from the Litchfield County Medical Association of Connecticut, was presented together with transfer card signed by Dr. H. B. Hanchett, president, and W. Bradford Walker, secretary. The secretary stated that the application cannot be acted upon until Doctor Phelps has been a resident of Placer County for six months.

Following the consideration of routine business, the president introduced Dr. Junius B. Harris, who briefly discussed legislative matters of interest to the medical society.

The president then introduced Dr. Frederick C. Warnshuis, who gave a résumé of the modern-day trend regarding health insurance and outlined the action of the House of Delegates pertaining to this matter during the past several sessions. He reviewed the work and plans for the future of the California Medical Association Committee on Public Relations, explaining how the members of the Placer County Medical Society can coöperate with the committee. Doctor Warnshuis extended a very cordial invitation to each member of the Society to call upon him at any time he can be of service.

Dr. C. G. Toland was next introduced. Doctor Toland reviewed the work of the California Medical Association during the past year. He outlined for the members the various activities which the State Association is sponsoring in order that the people of the State may become better acquainted with what organized medicine is doing for the promotion of better health and for the care of the sick. Among other things Doctor Toland discussed the plan of the Council for a speakers' bureau and also the plan to have exhibits at State and County fairs. He gave in detail the plan for the exhibit at the San Diego Fair this summer.

Doctor Toland was given a most enthusiastic reception.

Robert A. Peers, *Secretary.*

SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the County Charity Hospital in San Bernardino on Tuesday, April 2.

Special programs for the staff meetings of the Loma Linda Sanatorium and St. Bernardine's Hospital were announced.

Dr. F. E. Clough discussed the program for the postgraduate conference to be held on April 16.

A letter from Mr. Ben Read was read, outlining the various bills of medical interest now before the State Legislature.

The application for membership of Dr. Edward Mahon of Fontana was favorably voted upon. Dr. Laven Bramwell's transfer from the Orange County Society was accepted.

Dr. W. W. Roblee, our district councilor, made a brief address on the reorganization of the Woman's Auxiliary and related some of our present legislative problems.

Mr. H. P. Thoreson, director of the San Bernardino SERA, explained that the medical program was discontinued because of lack of funds, but that it would be renewed on a limited basis on Monday, April 8. Mr. Thoreson explained the new program and answered various questions.

Dr. J. M. Walton, who was to have given a case report, was unavoidably detained in a directors' meeting in Los Angeles, and telephoned his apologies and regrets.

The program of the evening was given as follows: Dr. F. F. Abbott, chairman, reported for the Committeed on Public Relations. Dr. A. B. Cook of Los Angeles gave an interesting talk on *Practical Aspects of the Goiter Problem.*

A. E. Varden, *Secretary.*

SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubroom, Stockton, at 8:15 p. m., Dr. C. A. Broaddus presiding.

The meeting was preceded by the customary supper meeting at the Clark Hotel, which was called to order at 6:15 p. m. There were twenty members present and three guests. The speakers of the evening were: Doctor Broaddus, who presented two cases; and Dr. D. R. Powell, who gave a report on the present status of the health legislation. Dr. Frank Vieira presented a patient, with demonstration of the reduction of a fractured os calcis, which was very interesting.

Doctor Broaddus spoke briefly on the question of parking of automobiles, the status of the financing of the Medico-Dental Club, and the parking situation surrounding the building. Doctor Van Meter reported on the extension course of the California Medical Association. Dr. P. B. Gallegos moved that the committee that is working on the extension course circu-

larize the Society members and determine definitely how many would be interested in bringing the course to Stockton. This was seconded by Doctor Doughty, and the motion carried. Doctor Cressman reported on the Membership Committee and its progress.

Mr. Davidson of the State Board of Medical Examiners gave a very interesting talk on problems confronting the medical investigator. He emphasized very much that lay laboratories could not exist if they were not patronized by practitioners, and advised very strongly against their continued patronage.

Doctor Broaddus announced that Doctor Nelson of Lodi was sick at the University Hospital. Doctor Doughty moved that the secretary write Doctor Nelson a letter, expressing the sympathy of the medical society. This was seconded by Doctor Hull, and the motion carried.

Dr. P. B. Gallegos announced that the Northern Medical Society would meet in Stockton on Saturday afternoon, April 27.

Doctors Reed and Johnstone presented the paper of the evening, on *Amebiasis*. This was illustrated with lantern and prepared microscopic slides. The paper evoked considerable discussion.

G. H. Rohrbacher, *Secretary*.

SONOMA COUNTY

The Sonoma County Medical Society held its regular meeting for the month of April in Cotati Inn, Cotati, on April 11, thirty-one guests and members being in attendance. Dr. D. G. Morton of the obstetric service of the University of California Hospital was present as guest speaker, and addressed the Society on the subject of the *Uses and Application of Obstetric Forceps*. His presentation was greatly appreciated by those present.

Dr. R. L. Zieber of Santa Rosa was elected to membership, and routine business was transacted. There was much discussion of the pressing medical problems of the day.

W. C. Shipley, *Secretary*.

TULARE COUNTY

A regular meeting of the Tulare County Medical Society was held on Sunday, March 24, at 6:30 p. m. at Motley's Café in Visalia, preceded by dinner. Dr. Ray Rosson, presiding.

Doctor Kohn, 1934 delegate to the special meeting of the California Medical Association House of Delegates, spoke on the actions taken.

Dr, William A. Winn of Springville was unanimously elected to membership.

An application for membership was received from Dr. John S. Glenn of Visalia and Exeter.

Dr. H. Glenn Bell, associate professor of surgery at the University of California Medical School, and in charge of postgraduate instruction in surgery, was our guest speaker. He read a most timely paper dealing with *The Early Surgical Treatment of Acute Cholecystitis*. Arguments for and against this trend of treatment were advanced and elaborated by means of lantern slides. Doctor Bell favors the early surgical treatment of the acute gall-bladder. General discussion followed his paper.

The remainder of the evening was then devoted to a rehearing of the events and actions leading to the recent special meeting. Doctor Kohn voiced his personal objections to the action taken by the Society at the last meeting and to the statements appearing in the local paper, and a letter to the secretary was read setting forth his objections.

After lengthy discussion it was felt the matter should be deferred for a later opinion.

Karl F. Weiss, *Secretary*.

VENTURA COUNTY

The monthly meeting of the Ventura County Medical Society was held in the Ventura County Clinic Building on Tuesday, April 9.

Communications read were:

A resolution from the Industrial Accident Section of the Los Angeles County Medical Association condemning the proposed cut in the fee schedule for industrial accident cases.

A letter from the American Medical Association differentiating between membership and fellowship in the association.

A letter from the State Secretary in regard to the x-ray fee schedule. Also the one dealing with SERA cases.

The above resolution was heartily endorsed. Our delegate was instructed to abide by the recommendations of the Association's special committee in regard to the x-ray fee schedule. Doctor Homer was appointed chairman of the committee to coöperate with the local relief administrator. No definite action was taken, as the county administrator had received no instructions from the state administrator.

Due to lack of volunteers for duty in the public health educational program, it was decided to draft speakers for the various communities in the county.

Dr. Joseph Risser of Los Angeles, who was introduced by Dr. Sterling Clark, gave an illustrated lecture on *Scoliosis*. A good discussion ensued.

A. A. Morrison, *Secretary*.

CHANGES IN MEMBERSHIP

(New Members (81)

Alameda County.—Ernest A. Lopez, John P. Martin.

Contra Costa County.—Tim Leon.

Los Angeles County—

Edwin A. Beard
R. Allen Behrendt
Louis O. Bennett
John B. Dooley
Arthur N. Bobbitt
Louis Boonshaft
William W. Braithwaite
Frank O. Brigham
Clyde F. Browning
L. Dudley Bumpus
Edward M. Butt
Charles M. Conkling
Ernest D. Cook
Burt Lee Doane
Leland W. Ellis
A. I. Epstein
Darius Eshoo
Jacob F. Feldman
Harry I. Geshelin
Arnold L. Gibson
George H. Ham
Joseph W. Hankins
Thomas E. W. Harding
Harold Harris
Harry H. Heidenreich
N. G. Hickey
Arthur E. Hollenbeck
Howard E. Horner
Delia A. Lynch
E. F. Maginn
David G. Miller
Robert R. Montgomery
Francis J. Morris
John R. Neal
Thomas J. O'Neill
Solomon Reina
Frank M. Schmidt
Hollis E. Sides
Robert C. Smedley
Bernard H. Smith
Richard C. Smith
Joel J. Pressman
David T. Proctor
Lester H. Rhymes
James Rosoff
Frank W. Young
Byron K. Zaring

Mendocino County.—Charles A. Craig, Charles W. Leach.

Napa County.—Avonia E. Kiser, C. Lyon Wood.

Orange County.—George Paulson, Erving L. Rogers.

Placer County.—Ellert E. Lundegaard, Vernon W. Padgett.

Sacramento County.—Elliott L. Adams.

San Bernardino County.—Howard D. Inghram, James W. Moreland.

San Diego County.—William H. Halsey, L. J. Langlois.

San Francisco County.—Elizabeth Chabanoff, Elson J. Masters, Alice Potter, Francis Rochez, Charles L. Rubenstein, Edith M. Stoker, William A. Sumner, Frederick C. Warnshuis.

San Luis Obispo County.—Harry McGarvey.

San Mateo County.—John N. Blood, Charles O. Morse.

Santa Clara County.—Marshall E. Porter, John C. Sharp, John C. Wilson.

Solano County.—Carlton C. Purviance.

Stanislaus County.—Joseph L. Azevedo, Andrew Van de Pol, Harris R. Wilson.

Transferred (3)

Charles Benninger, Jr., from San Francisco County to Butte County.

Lavon Bramwell, from Orange County to San Bernardino County.

Frederick J. Crease, from Kern County to Los Angeles County.

Resigned (3)

E. M. Bixby, from San Francisco County.

Ervin J. Caspar, from San Francisco County.

Clarence Crane, from Humboldt County.

In Memoriam

Kelley, Gilbert A. Died at Reno, January 27, 1935, age 46. Graduate of the College of Physicians and Surgeons, Los Angeles, 1913, and licensed in California the same year. Doctor Kelley was a member of the Fresno County Medical Association, the California Medical Association, and the American Medical Association.

✠

Moore, Dwight S. Died at Pasadena, March 16, 1935, age 69. Graduate of the University of Nebraska College of Medicine, 1887. Licensed in California in 1912. Doctor Moore was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

CANCER COMMISSION*

Sunday Conferences

Sunday, May 12, at the Ahwahnee, the usual microscopic pathology and radiology conference will be held.

The Pathology Conference will begin at 10 a. m. and members will need to arrive in the Valley the evening before or drive in from Merced early Sunday morning.

No microscopes will be available and it will be necessary for each member to bring his own.

Space will be limited to forty. Members desiring to attend should register at once with the committee or with the secretary of the Cancer Commission, 450 Sutter Street, San Francisco.

Committee on Pathology Conference:

Z. E. Bolin
R. A. Glenn

Radiology Conference.—In view of the examinations being held in San Francisco by the American Board of Radiology it is proposed to hold only an afternoon session of the conference this year. The session, therefore, will be between 2 and 5 p. m., and will be held only if a sufficient number of members or registrations are received.

Yosemite Valley may be reached by train from San Francisco in ample time to attend this meeting, or may be reached by automobile from most parts of the state in an average time of about seven hours.

If you will attend the conference, will you kindly notify the undersigned at once?

The Committee on X-Ray Malignance Conference:

L. H. Garland
R. R. Newell
A. C. Siefert

* The Cancer Commission was brought into being by the House of Delegates of the California Medical Association to aid in the furtherance of all efforts to combat cancer. The roster of officers and the central office of the Commission to which communications may be sent is printed in this issue of California and Western Medicine (see front cover directory). This column is conducted by the Secretaries of the Commission.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. PHILIP SCHUYLER DOANE President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

New County Prospects.—Mrs. Arthur W. Walker of Riverside, a councilor-at-large, and a member of the State Committee on Membership and Organization, has reported to the state president, Mrs. Philip Schuyler Doane, that an Auxiliary unit is to be formed in San Bernardino early in May. At the March meeting of the Riverside County Auxiliary, which Mrs. Doane attended and addressed, San Bernardino sent representatives and expressed a desire to reorganize. Such plans are now proceeding under the leadership of Mrs. Walter Pritchard of San Bernardino. Word has come, too, from Mrs. Fred J. Davis of Westwood that eligibles from both Plumas and Lassen counties met on March 20, and during a grand flurry of sudden snow that in no way diminished their enthusiasm, decided to organize and wrote to Mrs. William H. Sargent of Oakland, State Chairman of Membership and Organization, for guidance. In February the Siskiyou County Medical Society wrote, expressing interest and asking organization procedure. So before the official year terminates in the annual convention at Yosemite, there will doubtless be one or even two more counties to add to the three already formed since last May. These are Kern, Santa Clara, and San Luis Obispo.

* * *

County Auxiliary Reports

Alameda County.—The Woman's Auxiliary to the Alameda County Medical Association held their March meeting on the 15th at the Claremont Country Club. Hostesses for the occasion were: Mrs. N. N. Ashley, and Mrs. Leonard and her committee. Luncheon preceded the afternoon program, at which Dr. Frederick C. Warnshuis, Speaker of the House of Delegates of the American Medical Association, and Secretary-Treasurer of the California Medical Association, spoke upon *Medical Legislation.*

The Alameda Auxiliary took an active part as a distinct unit in the Community Chest drive. Under the leadership of Mrs. William H. Sargent as colonel and Mrs. Leonard Barnard as major, a battalion of our members achieved the success of obtaining the full percentage of their quota. It was an interesting experience for the members, who gained much knowledge of conditions unknown to them before; and also performed a real service to the community as well.

Mrs. A. W. Henry, *Publicity Chairman.*

* * *

Contra Costa.—The Auxiliary to the Contra Costa Medical Society held their March meeting on the 12th at the home of Mrs. W. E. Cunningham of Richmond. The highlight of the business meeting was the election of officers for 1934-1935, who are: President, Mrs. H. L. Carpenter of Richmond; vice-president, Mrs. L. H. Hedges, also from Richmond; second vice-president, Mrs. M. L. Bolender of Walnut Creek; and secretary-treasurer, Mrs. Kaho Daily of Richmond.

The *Hygeia* chairman reported on her project of contacting schools in the county. Dues have been sent

* As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

in for fifteen members this year. Following the business session, Mrs. Cunningham invited the doctors for an hour of music. She presented several numbers, some of which were her own compositions. Following the musical program, dainty refreshments were served.

Mrs. S. N. Weil, *Secretary.*

* * *

Kern County.—The Kern County Medical Auxiliary met for their March meeting at the Hotel Padre in Bakersfield. Luncheon was served at tables gay with bouquets of wild flowers fresh from the fields near by. Mrs. N. N. Brown, county president, asked as honor guest and speaker of the day, Dr. J. P. Dunshee, State Director of Public Health, who, accompanied by Mrs. Dunshee, had come from Sacramento on a tour through the south. Doctor Dunshee, in a clear and concise speech, pictured the history of public health work in California and outlined the objectives of his department. To enlist community interest and coöperation in public health work, various civic groups and service clubs had been invited to send representatives, and all responded in fine spirit. There were present members from the Women's University Club, the seventh district of the Parent-Teacher Association, Exchange Club, Rotary, Kiwanis, Lions, the Dairymen's Association, Soroptomist, and the Women's Club of Bakersfield. Mrs. Brown announced at the close of the meeting that the Kern Auxiliary would support a standing committee to be ready to serve in the cause of health projects at any time. Mrs. Louis A. Packard was in charge of the reservations for the day, and Mrs. T. M. McNamara, Jr., assisted Mrs. Brown in the general arrangements.

Mrs. Louis A. Packard, *Secretary.*

* * *

Los Angeles County.—Over 150 members attended the luncheon meeting of the Woman's Auxiliary to the Los Angeles County Medical Association held at the Association building on March 26, our president, Mrs. John V. Barrow, presiding. The absence of one of our most cherished friends was keenly felt—that of Mrs. Doane, who is making a splendid recovery from a serious injury received while motoring. A wire to express our comradeship and flowers to cheer her progress were sent her direct from the meeting. Mrs. Barrow announced the appointment of Mrs. P. A. Quaintance, one of our members, as chairman of the health program for the tenth district of the Parent-Teacher Association.

In introducing the first of the two speakers of the day, Mrs. Mabel V. Socha, the president of the Board of Park Commissioners of the city, Mrs. Barrow mentioned the fine work done by this commission for the beautification of the city. Mrs. Socha spoke on the new Griffith Observatory on the Hollywood hills of the park, describing the Planetarium and several of the scientific exhibits, and depicting the addition to the educational and cultural life of the city of this fine contribution. The second speaker was Dr. Nadina R. Kavinoky, herself a doctor's wife, whose subject was *The Doctor's Wife in the Community.* She stressed the fact that we, as doctors' wives, should be active leaders within our field of influence in clubs, Parent-Teacher groups, and health organizations. Doctor Kavinoky stated that women need particular direction along two lines: one concerning reducing diets, and the other concerning abortions. She urged women to think in terms of the shattered lives resulting from ignorance and misinformation, and to remember the importance of emphasizing correct health information wherever possible.

On the calendar for the month were also two teas. Mrs. Clifford Wright entertained at her home in honor of the Hospitality Committee. Among the hostesses were: Mesdames Ward Rolland, Robert Carroll, John Martin Askey, E. Vincent Askey, E. B. Plimpton, R. B. Hope. Mrs. Edward Pallette, Mrs. John V. Barrow, Mrs. James F. Percy, and Mrs. Carl Howson poured. The second tea was the Assembly Tea, given under the direction of Mrs. Donald Charnock, and held at the home of Mrs. Frederick Turnbull. Mrs. Charnock was assisted by Mrs. C. E. Phillips, Mrs. Newell Jones and Mrs. H. F. Whalman, with Mrs. Eliot Alden presiding at the tea table. Mrs. John Barrow introduced Dr. John Crossen, who explained some of the health problems in which he felt the Auxiliary could take an active interest. Mrs. Paul Quaintance told of her work in the Parent-Teacher Association. There were eight new members pledged and great interest was shown at this first of the assembly district functions.

In conjunction with the Public Health League the Auxiliary has been at work this month sending messages encouraging favorable action on Bills 954 and 128. As a result of energetic campaigning on the part of organized districts, hundreds of letters and telegrams were dispatched to Sacramento by lay individuals.

Mrs. Harold Crowe, *Corresponding Secretary.*

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Orange County.—The Woman's Auxiliary to the Orange County Medical Association were guests at the home of Dr. Harry G. Huffman on Riverside Drive in Santa Ana for their last meeting, and enjoyed the hospitality of Mrs. Huffman, Mrs. D. C. Cowles, Mrs. Milo K. Tedstrom, and Mrs. Kenneth Sutherland. Mrs. Hiram M. Currey and her Nominating Committee, Mrs. H. A. Johnston and Mrs. H. McVicker Smith, reported their choice of Mrs. Ray Green as president, Mrs. Sutherland as vice-president, Mrs. E. W. Kersten, as secretary, and Mrs. G. W. Olson as treasurer, in anticipation of the election in May. Discussion of magazine articles on antivivisection and of measures before the State Legislature on the same subject was held, and Mrs. Green summarized some of these articles, including one by Dr. A. C. Ivy of Northwestern University, which was written to bring out the real truths of the antivivisection crusade.

Delegates named for the annual convention in the Yosemite in May are: Mesdames Hiram Currey, Harry Huffman, Milo Tedstrom and Ray Green, with Mesdames Dexter Ball, G. W. Olson, Harry E. Zaiser and G. Emmett Raitt as alternates. Mrs. Olson and Mrs. C. G. Curtis had planned the afternoon's musical entertainment of solos, trio selections, and readings, which delighted everyone. Tea from a beautiful flower-laden table closed the festivities of the day.

Elizabeth M. Sutherland, *Secretary.*

* * *

Sacramento County.—The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. E. T. Rulison on March 19, with the president, Mrs. Frederick N. Scatena, presiding. Delegates to the State convention were chosen as follows: Mrs. Harry Kanner, Mrs. Orrin Cook, and Mrs. George Briggs; alternates, Mrs. P. H. Guttman, Mrs. Anthony Boscoe, and Mrs. W. J. Van Den Berg. An invitation to the Placerville Women's Club on March 28 from Mrs. William Reckers for the members of the Auxiliary and their husbands to hear Mr. Frederick Blanshard give his characterization of the life of Dickens was read, and transportation offered for the trip.

Mrs. A. M. Henderson presented the special guests for the evening, the superintendents of nurses at the Sutter, the Mercy, and the County hospitals. Mrs. Helen Sparks of the Sutter Hospital spoke on the work of the doctors and nurses' official registry. Following this, Mrs. T. Binkley gave a most interesting synopsis of "The Great Waltz," which she had seen while in New York. Mr. James W. King played with fine expression the music of "The Great Waltz" as an accompaniment, and made the review intensely interesting and dramatic. After the review Mrs. E. C. Hennessy sang several numbers, accompanied by Mr. King. The entire program was greatly enjoyed by the more than fifty members present.

Mrs. Rulison, assisted by Mesdames W. P. Christman, R. Soutar, George Foster, A. R. Boscoe, L. C. Barrette, E. F. Graham and R. Bramhall, served a delicious tea from a beautifully decorated table.

SARAH L. BRENDEL, *Corresponding Secretary.*

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San Diego County. — The regular meeting of the Woman's Auxiliary to the San Diego County Medical Society was held at the San Diego Club on March 12. The state president, Mrs. Philip Schuyler Doane, was honor guest and speaker. She inspired the Auxiliary to greater efforts by reports of the splendid achievements of the other counties of the State. She told of the excellent speakers to be heard at the convention of the California Medical Association in May at Yosemite. Her talk was most delightful and thoroughly enjoyed.

The following recommendation was read, submitted to a vote, and accepted: "The Board recommends that the medical Auxiliary show their approval of the Visiting Nurses' Association and of their work in our city by donating the sum of $25, the money to be earned by the Auxiliary." It was also decided that the Auxiliary will sponsor a play written by Dr. Lloyd Thompson, a member of the San Diego County Medical Society, and that the proceeds from the play will go on the fund for the Pool for Crippled Children.

Mrs. Emil Black, our president, expressed appreciation for the delightful Valentine's day tea, to which the Naval Medical Auxiliary invited the members of the San Diego County Auxiliary. Our organization gave a most successful dinner dance at the San Diego Club on March 9, for which about 120 reservations were made.

LUCILE NEWTON, *Secretary.*

NEVADA STATE MEDICAL ASSOCIATION

HORACE J. BROWN, M.D.....Associate Editor for Nevada

* * *

E. E. HAMER, Carson City.....President
R. O. SCHOFIELD, Boulder City.....President-Elect
C. E. SECOR, Elko.....First Vice-President
HARRY W. SAWYER, Fallon Second Vice-President
HORACE J. BROWN, Reno.....Secretary-Treasurer

OFFICIAL NOTICE

Change of Date of Annual Session.—The annual meeting of the Nevada State Medical Association will be held on October 25 and 26 at Elko, instead of September 13 and 14 as previously announced.

COMPONENT COUNTY MEDICAL SOCIETIES

WASHOE COUNTY

At the regular monthly meeting of the Washoe County Medical Society, which was held in the State Building on April 9, Dr. L. A. Emge, professor of obstetrics and gynecology at the Stanford University School of Medicine, was guest speaker. Doctor Emge chose as his subjects:

(1) What has heat to offer in the treatment of gonorrhea in women?

(2) The treatment of intractable dysmenorrhea.

(3) The control of persistent pain in pelvic malignancies.

Beginning with the subject of (1) gonorrhea in women, Doctor Emge gave as his opinion that gonorrhea, like typhoid fever, is a self-limited disease, and if left strictly alone will tend toward self-cure. He warned against meddlesome treatments and urged that no local treatment should be used unless absolutely necessary for cleanliness and comfort. He also pointed out that it is better to treat urethral involvement by internal medication, preferably salicylic hexamethylenamin, and an increase in fluid intake, than by local instillation. He also spoke about smears, pointing out that gonococci usually disappear in from four to six months, except in Skene's glands, where they are often present from twelve to eighteen months. In this connection he touched on the question of recurrence of the disease, which he considers questionable and which he thinks is more likely a new infection, because gonorrhea does not necessarily produce immunity. He cited a number of therapeutic measures to be used in the late subacute and the early chronic cases, outlining various forms of treatment, including destruction of Skene's and Bartholin's glands by fulguration or cauterization, and of the cervix by desiccation or cauterization. For upper pelvic pathology, resulting from either the primary or secondary infection, he advocated hyperpyrexia (hyperthermia) as carried out in his clinic by the high temperature bath method. He showed that the immediate salvage is somewhere around 60 per cent. The results obtained justified postponement of surgery in most instances, and in fact, the surgical instrument in this series has been reduced to a very small fraction of the cases seen. Diathermy was discussed, but Doctor Emge was not favorably impressed with the final result.

(2) The treatment of intractable dysmenorrhea by alcoholic block of Frankenhauser's ganglia.

The anatomy was reviewed, and the technique as originally suggested by Blos of Germany was discussed. Doctor Emge pointed out that intractable dysmenorrhea is a very rare condition, and that most dysmenorrheas are readily relieved by other measures. He spoke in particular of those types which respond to emmenin, laying stress on the fact that the psychoneurotic disturbances accompanying dysmenorrhea require special attention. He felt that the present trend toward surgical treatment by resection of the presacral nerve is unjustified, and that in most instances sufferers from primary dysmenorrhea can be relieved by the alcoholic block of the pelvic sympathetic nervous system, using 70 per cent alcohol containing 5 per cent novocain. In this lantern slide demonstrations he showed the technique, which is simple and, if followed accurately, quite free from danger.

(3) The control of pain in pelvic carcinoma.

Doctor Emge reviewed the work done at the Highland Hospital by Doctor DePuy, and showed the technique of injecting one cubic centimeter of absolute alcohol into the spinal canal as advocated by Dr. Clarence DePuy. He cited his own experiences and stated that relief is usually obtained for a period of six months. He emphasized that the danger of this method is trauma to the cord, which can be readily avoided, and the possibility of producing a temporary bladder paralysis.

A short general discussion took place after the presentation of the subjects.

THOMAS W. BATH, *Secretary.*

Can Modify Heritage.—Putting equal stress on environment and heredity is an excellent point of view for the mother to take in the problem of rearing her children. "We are likely to say that nothing can be done about inherited tendencies, but really a great deal can be done by way of modifying them, encouraging the good and discouraging the bad traits." This is the opinion of Dr. Herbert B. Wilcox given in an article on child training and disease.

Though a child starts his individual development either helped or hindered by the kind of inheritance that has come down to him from his forbears, he is more likely to inherit favorable than unfavorable traits. For that reason, inheritance is by no means the only thing and probably not the most important thing that determines mental and physical make-up. The right kind of treatment will greatly influence any inherited tendencies.

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

California Medical Association, Yosemite National Park, May 13-16, 1935. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

Nevada State Medical Association, Elko, Nevada, October 25-26, 1935. Horace J. Brown, P. O. Box 698, Reno, Secretary.

Medical Broadcasts*

American Medical Association Health Talks. — The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, central standard time.

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4 to 4:15, central standard time.

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San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of May is as follows:

Tuesday, May 7—KJBS, 11:15 a. m., and KFRC, 1:15 p.m.
Tuesday, May 14—KJBS, 11:15 a.m., and KFRC, 1:15 p.m.
Tuesday, May 21—KJBS, 11:15 a.m., and KFRC, 1:15 p.m.
Tuesday, May 28—KJBS, 11:15 a.m., and KFRC, 1:15 p.m.

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Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of May is as follows:

Saturday, May 4—KFI, 9 a.m. Subject: The New Frontier.
Saturday, May 4—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, May 7—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, May 11—KFI, 9 a. m. Subject: The New Frontier.
Saturday, May 11—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, May 14—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, May 18—KFI, 9 a. m. Subject: The New Frontier.
Saturday, May 18—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, May 21—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, May 25—KFI, 9 a. m. Subject: The New Frontier.
Saturday, May 25—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, May 28—KECA, 11:15 a. m. Subject: The New Frontier.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Economics.—Social experimentation requires many generations if it is to result in anything of lasting value. Results never appear in the generation which embarked upon experimentation. The great trouble in America is that some of us are trying to bite off in one session of Congress what it has taken Europe fifty years to set in motion.

We are not standpatters. We are willing to try any experiment which looks as though it might be an answer to the modern problem of the care of the sick poor. But it must be a controlled experiment. We must be assured, so far as we can control it, that standards of practice will not be lowered.

Among the interesting points that the operation of federal relief has brought to our attention is the matter of what doctors shall be upon the relief lists. . . .

Maternity and Child Health Provisions in Federal Security Bill.—A recent United Press dispatch was as follows:

"The Social Security Bill would make a start toward a national program to safeguard the children of America from economic and physical hazards endangering their happiness.

"The comparatively small appropriation provided for such purposes is designed to force states to adopt certain minimum standards for child aid.

"Under the bill the Federal Government would contribute these amounts to states with plans meeting federal requirements: $3,800,000 for maternal and child health aid; $2,850,000 for crippled children aid; $1,500,000 for child welfare; $841,000 for vocational rehabilitation.

"According to Katharine Lenroot, chief of the Labor Department's Children's Bureau, the program under the bill 'is in no sense representative of a complete child-welfare or child-health program in this country.' 'The provisions,' she testified before a House committee, 'would only attempt to make universally available throughout the United States certain minimum measures of public protection without which any private effort or any purely local effort is bound to be spotty and to be most inadequate in the places and areas where children are in the greatest need.'

"As the years go by, if the bill is enacted, there are plans for broadening its scope.

"The maternal and child health aid provision is designed 'to promote health of mothers and children, especially in rural areas and areas where there is severe economic distress.' The $3,800,000 appropriation would be divided among the states partly on the basis of live births and partly according to financial needs. The states also must provide contributions.

"For crippled children the bill sets aside $2,850,000, divided $20,000 to each state with an approved plan, and the remainder divided on a basis of the number of crippled children in need of aid.

"The Federal Government also would divide among the states annually $1,500,000 for adequate services 'to protect and care for homeless, dependent and neglected children.' Each state would receive $10,000 and a proportionate share of the remainder on the basis of their rural population proportion.

"The bill appropriates $841,000 for aiding states in vocational rehabilitation of physically disabled youths. "It carries $8,000,000 for public health work, allotted to states on the basis of population, special health problems, and financial needs. In addition, $2,000,000 is provided for federal public health service investigations of disease and sanitation, especially in rural areas."

Scientists Do Advanced Work in California.—A survey published in the *Princeton Alumni Weekly* indicates that more promising young chemists, mathematicians and psysicists—winners of coveted fellowships of the National Research Council—have done their work in California than in any other state.

Thirty-seven products of the graduate school of the University of California and thirty-one holders of higher degrees from the California Institute of Technology have won National Research Council grants in the three physical sciences, the receipt of which, the article points out, "is counted one of the highest honors for a young scientist—and an honor both for the university which trained him and the university to which he goes for his advanced work."

Seventy-nine physical scientists, trained at other universities, have chosen to work, under their grants, at California Institute of Technology and forty at the University of California.

Thus 187 fellowship holders have either been produced in California or have worked in it, a record which surpasses that of any other state. Massachusets is second with 167.

Contraceptives and Cancer.—The American Society for the Control of Cancer has the following to say on this subject:

"With the rapidly extending and increasing use of contraceptive methods come long debated relationships between certain of these methods and the incidence of uterine or vaginal cancer assumes a position of greater importance.

"Two general types of contraceptive procedure are to be considered—the chemical and the mechanical. A third method, namely, that of sterilization can be dismissed with the unfortunate and revealing statement that no body of available data is recorded which enables anyone to state whether sterilized women have less cancer, more cancer or the same amount of cancer as fertile individuals.

"Chemical contraception is based on the spermicidal efficiency of the substance or substances used. The question of the possibility that such methods may allow injured spermatozoa to complete the process of fertilization need not be considered here. The point at issue is the potentiality for setting up chronic irritation which some spermicidal chemicals unquestionably possess. In as much as other available spermicides do not possess this quality, the real need is for information which will enable the layman to distinguish between the irritating and the non-irritating chemicals so that the latter may always be chosen.

"Mechanical contraception relies on a devise which will prevent the spermatozoa from entering the uterus and completing the process of fertilization.

"In this case the possibility of irritation is again the question to be considered. Mechanical devices of metal or of other hard substances which may produce trauma or by surface contact irritate the lining of the female reproductive tract should always be avoided.

"Several types of mechanical device made of non-irritating material are in general use. There is no evidence that these have any carcinogenic action whatever.

"It should also be pointed out that abortion, especially that which is self-induced by mechanical means, is fraught with grave dangers.

"The whole matter resolves itself to a simple process of utilizing intelligently what is already known of the relationship between chronic irritation and cancer, to avoid carefully the use of any contraceptive method which involves that unnecessary and dangerous risk. This can be done easily and effectively and should result in making clear to those of the general public who employ contraceptives the fact that no casual relationship between contraception and the incidence of cancer need exist."

Academy of Physical Medicine.—The annual meeting will be held June 12 and 13, at the Claridge Hotel, Atlantic City, New Jersey. For further details, address Arthur H. Ring, M. D., secretary-treasurer, Arlington, Massachusetts.

American Public Health Association.—The sixty-fourth annual meeting of the American Public Health Association will be held in Milwaukee, Wisconsin, October 7 to 10, 1935. This organization is a society of 4,500 professional public health workers whose annual sessions review developments in health protection and promotion, and outline plans and policies for future advances.

A health exhibit featuring commercial, scientific and educational displays is a feature of the American Public Health Association annual meetings and will be conducted as usual at Milwaukee.

The preliminary program plans include special sessions on The Role of a Health Department in a Program of Social Security, Mental Hygiene, Professional Education, Veterinary Public Health, Diphtheria Immunization, and a session upon the history and achievements of the Association's Committee on Administrative Practice, celebrating its fifteenth anniversary.

The ten sections of the association—Health Officers, Laboratory, Vital Statistics, public Health Engineering, Industrial Hygiene, Food and Nutrition, Child Hygiene, Public Health Education, Public Health Nursing, Epidemiology — will discuss pneumonia, trench mouth, syphilis, measles, outdoor bathing places, scarlet fever, milk sanitation, water sanitation, foods, health education, and many other topics representing the responsibilities of health authorities.

The chairman of the local Committee on Arrangements is Dr. John P. Koehler, Health Officer of Milwaukee. The American Public Health Association at 50 West Fiftieth Street, New York City, will be glad to send program outlines on request.

Western Branch, American Public Health Association.—The sixth annual meeting of the Western Branch, American Public Health Association, will be held in Helena, Montana, July 1, 2 and 3. Public health matters of special interest to the West will be discussed, and a program of unusual value is being arranged by Dr. W. F. Cogswell, State Health Officer of Montana, president-elect of the Western Branch, and chairman of the Committee on Meetings and Publications.

Public health problems among western Indians; peculiarities of western water and sewage disposal systems; new plans for public health developments by the Federal Government; latest advances in the control of Rocky Mountain spotted fever, undulant fever, tularemia, silicosis, psittacosis; home nursing of communicable diseases; various aspects of tuberculosis, and modern advances in health education are among the subjects to be discussed. Among the distinguished guests expected are Miss Katherine Lenroot, United States Children's Bureau; Miss Josephine Roche, Third Assistant Secretary of the Treasury; Dr. Thomas R. Crowder, chief surgeon of the Pullman Company; Dr. A. J. Chesley, State Health Officer of Minnesota; Dr. Thomas A. Parran, Health Commissioner of New York; Dr. E. L. Bishop, Medical Director of the Tennessee Valley Authority; Mrs. Helen LaMalle, superintendent of nursing, Metropolitan Life Insurance Company, New York City, and others.

The meeting will be held in conjunction with the annual meeting of the Montana State Medical Association.

For information, address W. P. Shepard, M. D., 600 Stockton Street, San Francisco, secretary.

Pending Health Legislation Concerning Laboratories

Senate Bill 21.—S. B. 21, introduced by Senator Herbert W. Slater and referred to the Committee on Public Health and Quarantine. Under the provisions of this bill it would be unlawful to sell or distribute any serum, vaccine, bacterial culture or virus not produced by laboratories approved by the Bureau of Laboratories of the State Department of Public Health. It requires the State Board of Public Health to make rules and regulations for the production, labeling and storage of serums, vaccines and similar products, except those specifically approved and licensed by the United States Public Health Service. A fee of $5 for license is required the first of the year which shall be renewable upon the payment of an annual fee of $2. The bill provides that reasonable charges be made for analyzing and testing the products of the licensee. Licenses may be revoked or suspended for cause. Funds collected under the provisions of the act will be credited to the general fund.

Senate Bill 98.—S. B. 98, introduced by Senator Herbert W. Slater and referred to the Committee on Public Health and Quarantine. This bill provides for the licensure of persons who perform diagnostic tests on material from persons who may suffer from infectious or contagious diseases. Licensees must hold certificate as qualified technician issued by the State Board of Public Health. Licensed physicians are exempt from the provisions of the act in so far as it applies to examinations of their own patients. Special examiners may be employed by the board to conduct examinations of technicians, payment to be made to such examiners from fees collected from applicants for examination. A fee of $5 is required with the application and an annual renewal fee not exceeding $1 is required. Nonpayment of fee brings cancellation of license. Fees are to be credited to a special fund for the administration of the act. This bill does not license laboratories nor does it in any way restrict the conduct of laboratories, but it does provide for the certification of technicians working in such laboratories in so far as procedures involving communicable disease specimens are concerned. Provision is made that the act shall not become effective before one year after its passage.

Senate Bill 392.—S. B. 392, introduced by Senator H. L. Parkman and referred to the Committee on Public Health and Quarantine. This bill relates to the conduct of clinical laboratories and the licensing of technologists and defines a chemical laboratory and technologist. A technologist is defined as any practitioner of the healing arts licensed in California who shall specialize in general clinical laboratory work for at least three years, and any other person who, for a period of more than eight years prior to the enactment of the bill shall have been engaged continuously in the direction of a clinical laboratory in California, as well as other persons who may qualify through examinations conducted under rules and regulations promulgated by the State Board of Public Health.

Assembly Bill 1943, introduced by Assemblyman H. B. Scudder and referred to the Committee on Medical and Dental Laws. This bill provides for the certification of laboratory technicians by the State Board of Public Health, but limits those who may conduct laboratories to doctors of medicine. Annual permit fees are fixed at not less than $5 and not more than $50 as established by the State Board of Public Health.

Pure Foods and Drugs Act.—The press service of the United States Department of Agriculture reports as follows:

"The makers of Kal, Inc., and Bernard Ackerman, shippers of 'Kal,' were fined a total of $153 at Los Angeles. 'Kal,' a compound of lime, prosphorus, rice by-products, a malt product and cocoa, was labeled with claims of benefit in tooth decay, acidosis, nervous irregularities, rickets, anemia, pyorrhea, glandular disorders, high and low blood pressure, asthma, hay fever and tuberculosis, which claims the government alleged were false and fraudulent, as an article of such composition could have no appreciable effect against those disease conditions. 'Kal' sold at 65 cents a pound.

"Patent medicines confiscated last month included 'Pyorrhex Chewing Gum,' labeled as a preventive of pyorrhea; 'Poloris Dental Poultice,' for toothache, abscess, pyorrhea and gingivitis; 'Lucorol' for women; 'Tussamag,' a cough syrup bearing claims for bronchitis, asthma, whooping cough, pneumonia and tuberculosis; 'Ditman's Sea Salt,' an impure rock salt labeled as a treatment for rheumatism and debility; 'Chlorine Respirine,' a mixture of petrolatum with calcium compounds, for bronchitis, laryngitis, whooping cough and influenza; 'Kay's Ointment,' 'Kay's Leg Powder' and 'Kay's Oil,' for leg sores; 'Vaporine Ointment' for coughs, congestion, catarrh and tonsillitis; and 'Antiseptine,' which was found to be not antiseptic, and bore claims of benefit in cases of laryngitis, pharyngitis, tonsillitis, sore throat, rheumatism and dandruff. In all instances, the government alleged that the medicinal claims made for these articles were in excess of their possibilities."

Two men have each been sentenced to two years in a federal penitentiary for conspiracy to violate the Federal Foods and Drugs Act by falsely labeling and selling "Warm Springs Crystal Compound" as coming from the Georgia springs of that name. The "crystals" did not come from that source and were only a simple laxative composed of Glauber's salts, similar in action to Epsom salts. The "crystals" cost only a few cents a pound and were sold for a dollar a pound.

Pan-American Medical Association. — Announcement of a floating congress to Brazil and West Indies, July 18 to August 28,* 1935, is as follows:

The Pan-American Medical Association announces its sixth scientific congress, to be held this coming summer in the form of a cruise to Brazil and the West Indies.

This congress is of interest to all medical men because of its very definite scientific advantages, the opportunity it offers to establish social contacts of lasting value, and its unusual attractions as a vacation voyage, coming at a season of the year when one can most conveniently be away from active practice.

Here are a few brief facts concerning the congress-cruise:

We shall sail from New York on July 18, returning on August 28.

Our ship is the steamship *Columbia,* the largest liner ever to cruise to South America. She offers the utmost in travel comfort and luxury, with the atmosphere of a smart beach club. Social and sports activities on board ship will be varied and delightful.

The itinerary includes Havana, Curacao, Trinidad, Santo Domingo and Jamaica in the West Indies, and Rio de Janeiro, Santos and Sao Paulo in Brazil, where we shall be welcomed with traditional Brazilian hospitality. Comprehensive programs of sightseeing may be enjoyed at all of the ports visited.

The medical activities will be divided into seventeen sections, representing all branches of medicine. The scientific program to be conducted during the voyage on the *Columbia* will consist of twenty-four papers to be presented before each one of these sections. The Brazilian medical profession has arranged scientific sessions at Rio de Janeiro and Sao Paulo with special exhibits at the famous Oswaldo Cruz Institute of Tropical Medicine and at the renowned Sao Paulo University with its Instituto Sero-Theropeutico.

It is the purpose of the congress to blend the best practical medical thought with the cultural influences of international contacts, and at the same time to provide a truly worth while travel experience.

Members of the medical profession, in good standing, are invited to join the congress-cruise with their wives and families. They may also invite a limited number of non-medical friends. All applications for cruise membership must be approved by the Committee on Credentials and Programs.

* See page 406 regarding change of date.

The officers of this Association have succeeded in obtaining the most reasonable rates possible for the forty-one-day cruise on such a luxurious liner.

Additional information can be obtained from Joseph J. Eller, director general, 745 Fifth Avenue, New York, N. Y., or Charles Pierre Mathé, vice-president, 450 Sutter Street, San Francisco, or Albert Soiland, regional director, 1407 South Hope Street, Los Angeles.

Thomas Cook & Son, Wagons-Lits, Inc., have been appointed official travel agents for the cruise and will handle all reservations, subject to the approval of the Association.

STATE HEALTH INSURANCE

The San Francisco *Chronicle*, under date of April 12, printed the following story of the State health insurance plan, as provided for in Senate Bill 454:

Establishment of a system of State health insurance for persons with incomes less than $3,000 annually was recommended to the legislature.

The recommendations followed a study of many months and carried with them the legislation to create a health service fund to be administered by the State.

Creation of a Health Insurance Commission of five members, to be appointed by the Governor, is provided for in a bill by Senators Edward H. Tickle, Carmel; Dan E. Williams, Chinese Flat; and Leonard J. Difani, Riverside. The three Senators, together with Celestine J. Sullivan, LL. D., composed the Senate committee on investigation of the high cost of sickness.

"The Health Service Insurance Act," states the committee report, "we believe is for the public good, based upon incontestable facts, the health rights and needs of the public."

To meet costs of such a system, provisions were made in the bill now before the Senate to set up a "health service fund" from contributions by employers and employees.

In brief, the fund contributions would be as follows:

It would be unlawful for any employer to deduct from the wages of any employee with respect to whom any amount is payable, a sum greater than 3½ per cent of the wage.

Private employers other than to whom certificates of compliance have been issued will pay to the Health Commission an amount equal to 5 per cent of wages paid to his employees. However, credits could be taken by the employer because of deductions for Workman's Compensation Insurance payments and income taxes for application against the 5 per cent levy.

Private employers would deduct 12 cents a day from the wages of casual employees and pay that amount into the State fund without further additional sums contributed by the employer.

State employees, other than casual employees, would pay into the State fund 3½ per cent of their wages. From the general and other funds of the State, the Government would pay another 1½ per cent of the wages of its employees to create a sufficient health insurance fund for them.

Employers maintaining their own health insurance organizations and hospitals would be granted compliance certificates. These employers, however, would be compelled to make payments to set up health insurance funds for the dependents of employees.

More than $100,000 was expended in the study of health needs in California. All of this money was contributed privately. [Thirty thousand dollars by the California Medical Association and seventy thousand dollars by the SERA, through the California State Board of Health.] The health survey contacted a total of 20,560 families. Medical facilities within the State were declared to be unevenly divided, and the State was found to have a higher proportion of physicians to the population than any other State in the Union. Hospitals were declared to be suffering from poor financial conditions. . . .

Free choice of physicians, dentists, and hospitals would be permitted those insured. It is estimated that two million persons would be affected by the State system.

* * *

Points in Senate Plan for Health Service Insurance.*

A commission of five members serving four years at a salary of $8,000 is to be appointed by the Governor.

Two members are to be physicians, who shall decide on all professional matters, including standards, service and compensation.

The commission shall appoint a physician as medical director and name his salary upon which no limits are set.

The commission shall appoint an advisory council of ten members, two of whom shall be representatives of the California Medical Association; the others representing dentists, nurses, hospitals, employers, employees, and agriculture.

The commission is to determine all rates and fees.

The commission is given control over all persons and groups furnishing any kind of benefit health service or any other medical, dental, or hospital service.

The commission may coöperate to improve public health.

The commission's judicial powers relative to the proposed health service are not subject to repeal.

All physicians, dentists, and agencies giving health service must be licensed by the commission.

Benefits would be available to any resident with an income less than $3,000, to his dependent spouse and minor children, provided he passes a physical examination.

The beneficiary must pay 50 per cent of the first professional visit, and 25 per cent of the first day's hospitalization.

Benefits would be as follows:

Service of physician limited to twenty-six weeks.

Services of laboratories as prescribed by physician.

Tooth extractions. Other therapeutic dental services prescribed by physician.

Prenatal and maternity treatment.

Hospital and nursing care prescribed by physician. Hospital care limited to 111 days; first twenty-five free, remainder at 15 per cent of cost.

Essential drugs and medicines prescribed by physician.

Employers giving similar service may continue such service under a certificate of compliance issued by the commission.

Premiums are to be directly proportional to the average annual net income. Minimum premium set for income of $1,000.

Employers must pay premiums equal to 5 per cent of employees' wages.

Employees' share is 3.5 per cent. Employer may lawfully deduct this amount from employees' wages.

Free choice of physician, dentist, and hospital is guaranteed.

Further benefits for a particular sickness are denied any patient refusing to follow treatment prescribed by attending physician.

Employers are held responsible for compliance with all the provisions of the Act.

* Reprinted from *Clearance*, Vol. 1, No. 6, April, 1935.

CORRESPONDENCE

Concerning A. B. 2397 (a County Hospital bill).*

To the Editor:—For your information I am enclosing copy of a letter to Mr. S. L. Heisinger, relative to Assembly Bill No. 2397

Sincerely,

J. C. Geiger, M. D.
Director of Public Health.

* * *

My dear Mr. Heisinger:

Replying to your letter of April 4, may I state that I have read very carefully Assembly Bill No. 2397, and at your request am giving you my impressions of the same.

As I see it, this bill will allow the Board of Supervisors, on a petition of 25 per cent of the registered voters of the county, to establish a system of hospital insurance and would place each county that adopted such a system in the position of caring not only for the indigents of the county, but for those well able to support hospitalization at their own expense. I feel that this is a vicious practice, particularly that portion of the first paragraph which provides that the subscribers may procure special service, private or semi-private rooms, additional or special nursing service for additional payment

This would clearly establish class in a public hospital maintained by the taxpayers, and I feel that the county has no right to embark on such an activity wherein they

* For other comments on this bill, see April issue of California and Western Medicine, page 273.

will definitely have in the same institution a system whereby unfortunates who might for the time be indigent are pointed out by classification as such.

I feel also that the county would lose control of its institution if the patients in said public institution were permitted to select their own doctors.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

Concerning a Medical Practice Act Amendment (Senate Bill 155).

Sacramento, April 4, 1935.

To the Editor:—In the March issue of CALIFORNIA AND WESTERN MEDICINE, page 229, in the list of public health bills, under the heading "Proposed Public Health Legislation," appears a comment on Senate Bill 155, amending Section 10 of the Medical Practice Act, which gives a wrong impression of the purposes of the bill. The notation indicates that said bill will lower existing standards. Such is not the case.

This bill is in line with resolutions passed some time ago by the Federation of State Medical Boards of the United States, and we understand supported by the Council on Medical Education and Hospitals of the American Medical Association.

Careful reading of the bill will disclose that graduates of foreign institutions, in addition to presenting documentary evidence of the completion of the required course of instruction in the California Medical Practice Act substantiated by a medical diploma from an approved foreign school and a license to practice medicine issued in the country where said school is located, must also complete a one-year interneship in an approved United States hospital, or complete the senior year in an approved medical school located in the United States before said applicant will be eligible to be admitted to a written examination for a license to practice in this State.

The records show a very heavy influx of foreign graduates, who seek to practice in the various states in the Union. Experience indicates the practical impossibility of verifying many of the credentials presented. No information can be obtained from Russia and but little from Germany.

Reports published in the American Medical Association journal of licenses issued in the State of New York indicate a surprising number of foreign licentiates admitted to practice in that state on endorsement of credentials only, no examination (unless it may be a knowledge of the English language only) having been required. These same applicants seek entry into California on their New York license so issued; however, they are all denied direct reciprocity because they fail to fulfill the statutory requirements of California's Medical Practice Act. Many file applications for written examination, and then our troubles begin in an endeavor to satisfactorily verify their credentials. This is made more complicated because of the universal European system of spending but a short time, *i. e.*, one or two semesters, in resident study at one institution. The credentials of many applicants from Germany show their claim to have attended at least six medical schools before obtaining the right to practice in that country.

We leave to the decision of the medical profession in California as to whether this legislation should be passed.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer, State Board of Medical Examiners.

Concerning change of sailing date in Pan-American cruise.

To the Editor:—Please note important change in ship, time of sailing, and shortening of Pan-American Medical Association's cruise, made necessary by the fact that the steamship *Columbia,* which had been chartered, has been discontinued from cruise service. The officers of the Pan-American Medical Association have succeeded in chartering the *Queen of Bermuda,* a most luxuriously equipped ship which has a private bath in every room. This, of itself, is a much desired convenience which will be appreciated by every traveling member. Another advantage, in the opinion of many of us, is that the sailing date has been advanced to June 29 from New York, on to Rio de Janeiro via the West Indies, returning August 1. Practically the same itinerary that was contemplated in the original cruise will be carried out.

ALBERT SOILAND,
Member-Governor of Cruise.

Concerning Industrial Accident Commission fee table.

To the Editor:—The following resolution has been unanimously endorsed by the Board of Councilors of the Los Angeles County Medical Association:

WHEREAS, We are advised that the State Compensation Insurance Fund has applied for a hearing before the Industrial Accident Commission for a reduction of 25 to 50 per cent in the fee schedule for professional services rendered industrial accident patients; and

WHEREAS, The fee schedule for professional services is already much below that for similar work in private practice; being in fact so low that the fees granted are really less than they should be when all the responsibilities of the Fund, the workers, and the physicians are honestly taken into account; and

WHEREAS, For the Fund to lower its fee schedule still more would work a gross injustice to physicians who as a class and as individuals are also workers, and who as a class give gratuitous service, which if translated into money values far exceeds that given by any other group to the care of indigent citizens; and

WHEREAS, Actuarial records increasingly show with the passing years that the best investment for the economic administration of an insurance carrier (and that includes the State Fund) is a personnel on the industrial panel of the ablest type of physicians; since through their services there are fewer temporary and permanent disabilities; and

WHEREAS, The organized medical profession of the State as represented by the California Medical Association and its component county societies, is opposed to such a reduction of fees; because to do so will be to the injury of the working men and women of California who come under the jurisdiction of the Workmen's Compensation Act, and be to the detriment and disadvantage of the State Treasury and to the State Fund, and would work a gross injustice upon the members of the medical profession, through whose efficient services much of the past success of the State Compensation Insurance Fund has been due; now, therefore, be it

Resolved, That on behalf of the organized medical profession of California, the Industrial Accident Section of the Los Angeles County Medical Association herewith respectfully requests the Industrial Accident Commission to take no such action as has been proposed by the State Compensation Insurance Fund; and be it further

Resolved, That copies of these resolutions be sent to His Excellency, Governor Frank Merriam, to each of the Fund commissioners, to the manager of the Fund, to the California Medical Association and to each of its component county societies, and to the official publication of the California Medical Association.

March 14, 1935.

INDUSTRIAL ACCIDENT SECTION OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.
By Floyd Thurber, M. D., Secretary.

Concerning communicable diseases.

To the Editor:—The Department of Public Health of the city and county of San Francisco submits the following:

MEETING OF THE ADVISORY COMMITTEE ON ACUTE ANTERIOR POLIOMYELITIS

At the invitation of the Director of Public Health, a special meeting of the Advisory Committee on acute anterior poliomyelitis was held at the San Francisco Hospital on April 4, 1935, to consider special questions of importance concerning poliomyelitis and other communicable diseases. The following resolutions and recommendations were unanimously adopted:

RESOLUTION ON POLIOMYELITIS VACCINE

WHEREAS, The use of vaccine for the active immunization against pollomyelitis is still in the experimental stage; and

WHEREAS, The duration of immunity, if any, so produced is unknown; and

WHEREAS, The determination of susceptible individuals is impractical with present methods; therefore, be it

Resolved, That the Advisory Poliomyelitis Committee recommends to the Director of Public Health that he take

no active stand favoring the use of this vaccine until its value has been more fully demonstrated.

The committee further recommends that the experimental administration of this vaccine be restricted to properly qualified research institutions. In addition, the committee is not convinced of the harmlessness of preparations containing the living virus of poliomyelitis.

In conclusion, the committee desires to quote from an abstract of an article by Maurice Brodie et al., in *Science*, Vol. 82, No. 2100, March 19, 1935:

"However, the incidence of the disease is so low and the preparation of the vaccine so expensive that its application is limited. It has been found that not only convalescents, but also many normal children, even in the susceptible age group, have antiviral substances in their blood. *Vaccination should be limited to those without any antibody.*" (The italics are ours.)

RECOMMENDATION ON SCARLET FEVER IMMUNIZATION

Despite the rising endemicity of scarlet fever in the city and county of San Francisco, the committee recommends to the Director of Public Health that immunization against scarlet fever should not be approved.

RECOMMENDATION ON PASSIVE IMMUNIZATION AGAINST MEASLES

The committee recognizes the value of whole blood convalescent serum and placental extract as an agent for the passive immunization of maximum six weeks' duration against measles. The committee is of the opinion that it should be administered only in special family or institutional groups or under other extenuating circumstances when indicated in the judgment of the attending physician.

When such preparations are used, the committee again wishes to emphasize that they should be prepared by accredited laboratories and under the standardization of technique formerly laid down by the Department of Public Health for the preparation of poliomyelitis serum.

RECOMMENDATION OF DIPHTHERIA IMMUNIZATION

The committee recommends immunization against diphtheria be done at the age of one year, and further states that this procedure is the responsibility of the physician in charge of the infant at that time.

Respectfully submitted by the committee:

K. F. Meyer, Ph.D.
W. P. Lucas, M.D.
E. B. Shaw, M.D.
H. K. Faber, M.D.
J. W. Ward, M.D.
I. W. Thorne, M.D.

Approved:
J. C. Geiger, M.D.,
Director of Public Health.

Concerning diphtheria immunization by physicians in private practice.

To the Editor:—Enclosed is a description of a plan for diphtheria immunization by private physicians to be followed in San Francisco.

On authority from the Director of Public Health.

April 9, 1935. Paul S. Barrett, M. D.,
Director, Bureau of Child Hygiene.

CONTINUOUS CAMPAIGN FOR IMMUNIZATION AGAINST DIPHTHERIA NECESSARY*

A movement of interest to physicians will be announced during the month of April by the May Day Committee of the State and Provincial Health Authorities of North America, together with the American Child Health Association, as the May Day-Child Health Day Project for 1935. A determined effort will be launched to promote diphtheria immunization. According to notifications sent to national health organizations and to the press, the objective was chosen because there has been no reduction since 1930 in the number of deaths from diphtheria throughout the United States. Some states have accomplished a notable reduction in the number of deaths; therefore it must follow that others have suffered increases. This means that diphtheria immunization in the United States has not been uniformly and consistently applied. The committee announces its belief that immunization should be the work of the private physician. State health officers will be asked to send a communication to each physician in the State urging (1) that he remind his patients who have children under school age of the need for immunization, (2) that he ask his patients to bring their children to be immunized, and (3) that he make it a routine of his practice in the future to immunize during the first year of life all babies under his care. The medical profession, which has never been enthusiastic about sporadic health drives, may well support this effort, which uses May Day merely as a taking-off place and a means of attracting the attention of the public. The objective of the plan is to immunize all children between the ages of six months and six years and to maintain this as a continuing service. It is hoped that coöperation will be developed in the states between the department of public health and the medical profession, since both agencies are necessary for the success of any community plan for diphtheria control. The Board of Trustees of the American Medical Association, on request of the American Child Health Association, urges physicians to assist and coöperate in this plan.

* Editorial in *The Journal of the American Medical Association* for March 16, 1935.

* * *

To the Physicians of San Francisco:—Last year the County Medical Society and the Department of Public Health inaugurated a campaign to encourage immunization of children by the private physician. The approach last year through publicity and pamphlets was to the public at large. The above editorial points out a fact which has been repeatedly called to the attention of the physicians that the responsibility for getting the work done rests with the physician himself. In other words, every physician doing this work must mention immunization to parents whenever a contact is made.

Not infrequently physicians are fearful lest their motives in urging immunization be considered of a mercenary nature. While public health education should never be considered commercial, it would seem advisable to protect the private physician from the possibility of such a criticism. The Director of Public Health, therefore, is pleased to approach the public through the physician himself. To this end a certificate as illustrated will be issued to physicians desiring to assist in the immunization campaign for display in their offices. In addition, copies of the accompanying letter will be delivered to physicians upon their request, to be sent out to bona fide patients of the physicians themselves.

It is hoped by this method to continue the campaign of education which was started last year to put immunization where it rightfully belongs—in the office of the privately practicing physician. It is requested, however, that only such physicians who actually intend to do immunization work shall request these letters and certificate.

With the opening of schools in August, the same publicity will be given to the subject of immunization as last year, both by the distribution of pamphlets by the Department of Public Health and by radio and other publicity by the County Medical Society. In the meantime, much may be accomplished toward establishing a continuous campaign of immunization by the medical profession.

* * *

To Parents and Guardians:—Your child has reached the age at which he should be protected from diphtheria. The records of your physician do not show that this has been done. Accordingly I am requesting him to send this letter to you in order that you may not lose valuable time, but take the first opportunity to protect your child against this disease.

Your physician, who is sending you this letter from me, is prepared to do the immunization work, and I personally urge upon you the necessity of attending to this beneficial procedure without delay.

* * *

This is to certify that ————, M. D., has enrolled in the National Diphtheria Immunization Campaign, beginning May 1, 1935, and, as an agent of the Department of Public Health, is authorized to urge parents of all unimmunized children to have the protective inoculations given by him.

[Seal] J. C. Geiger, M. D.,
Director of Public Health.

Concerning misbranded bread.

To the Editor—I am enclosing for your information a copy of an executive order issued by Doctor Geiger re the sale and distribution of breads labeled as possessing laxative properties.

T. P. Lydon,
Chief, Bureau of Food and Milk.

* * *

EXECUTIVE ORDER NO. 107

The manufacture, sale and distribution of bread and other bakery products so labeled as to indicate that the use of such products relieves constipation, or that said products possess laxative qualities, is hereby prohibited in this city and county.

Labeling of this character is in distinct violation of Section 5, Ordinance No. 1426 of the City and County of San Francisco, relative to misbranding and mislabeling of articles of food and drink. Statements of the type noted above are misleading and false; and, therefore, the use of such statements in the labeling of food products constitutes a violation of this section of the ordinance.

Manufacturers of bread and other bakery products are, therefore, accordingly directed to discontinue immediately the manufacture, sale and distribution of such products so labeled.

This order is in full force and effect March 29, 1935.

J. C. Geiger, M. D.,
Director of Public Health.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 5, May 1910

From Some Editorial Notes:

Department of Health.—As most of our readers are doubtless aware, a movement has been on foot for a number of years to secure the creation by the Federal Government of a Department of Public Health. The agitation was really commenced by the American Medical Association quite a few years ago. Later, a Committee of One Hundred of the American Association for the Advancement of Science was formed to do pretty much the same work. . . .

* * *

More on the Same.—It has been pointed out more than once in the *Journal* that few lawyers and almost no physicians really know anything about the medical practice law or the decisions pertaining to it. That is true of most prosecuting officers. It has been decided by the Supreme Court of this State that a license to practice medicine is not a piece of property belonging to the licensed physician; it is merely a police permit, subject to revocation at any time. In consequence it is not a duty of the Board of Examiners to prove that John Doe is *not* licensed, but it is the duty of John Doe to prove that he *is* licensed by producing a certificate if he has one; failing this he is an illegal practitioner. Ignorance of this decision (known as the Boo Doo Hong case) occasionally leads a prosecuting attorney to subpoena the board to produce the records in court and show that the accused is not licensed. . . .

* * *

The Worst Quacks.—The worst offenders are not the few men who have settled down here and there and are practicing without a license; they are the licensed physicians who have chosen to prostitute their profession to quackery. . . .

* * *

State Society Meeting.—For reasons already given, only a fragmentary account of the meeting of the State Society at Sacramento can be published this month. . . . The House of Delegates transacted a large amount of business in the two sessions held Tuesday and Wednesday nights. On the first night only the various reports of president, Council, secretary, editor, etc., and some resolutions and other matters of new business, were introduced. All these were referred to a special committee, consisting of H. Bert. Ellis, Los Angeles; Stanley Stillman, San Francisco; and W. J. G. Dawson, Eldridge. On Wednesday night this committee reported with its various recommendations. The most important matter before the Society, the continuance of the plan for malpractice defense, which was inaugurated by the Council July 1, 1909, was approved and continued permanently. Other details of the meeting will be reported in full in the June *Journal.*

Santa Barbara was selected as the place for the next meeting, and the following officers were elected: President, John C. King, Banning; first vice-president, A. B. Grosse, San Francisco; second vice-president, J. Henry Barbat, San Francisco; secretary, Philip Mills Jones. Councilors: Second District, George H. Kress, Los Angeles; Sixth District, C. G. Kenyon; Eighth District, James H. Parkinson; At-Large, F. M. Pottenger.

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, Page 15)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M. D.
Secretary-Treasurer

News

"The State Board of Medical Examiners today announced a list of sixty-two persons who successfully passed the state examinations held in Los Angeles last month. Fifty-six of the sixty-four applicants for physician and surgeon licenses and six of the seven for drugless practitioner licenses passed. Eugene J. Jorgenson, M. D., Los Angeles, had an average of 94 4/9 per cent, the highest mark in the test. . . ." (Los Angeles *Evening Post-Record,* March 18, 1935.)

"Prosecution of shyster lawyers, unethical doctors and citizens who combine to fake automobile accidents in an effort to collect damages will be pushed by the California Traffic Safety Council, it was announced yesterday by Guy C. Macdonald, Secretary. Effort will be made to disbar the lawyer engaging in such type of practice and to revoke the license of doctors offering false testimony as to the extent of injuries." (San Francisco *Chronicle,* March 13, 1935.)

"Agreement on fees for physicians who attend persons on relief has been reached by S. E. R. A. officials and the California Medical Society, it was announced today. Three doctors from each County Medical Society will work with county administrators under a program outlined by Frank Y. McLaughlin, S. E. R. A. administrator. They will be $1.25 for office calls and $1.75 for house visits." (Oakland *Post-Enquirer,* March 27, 1935.)

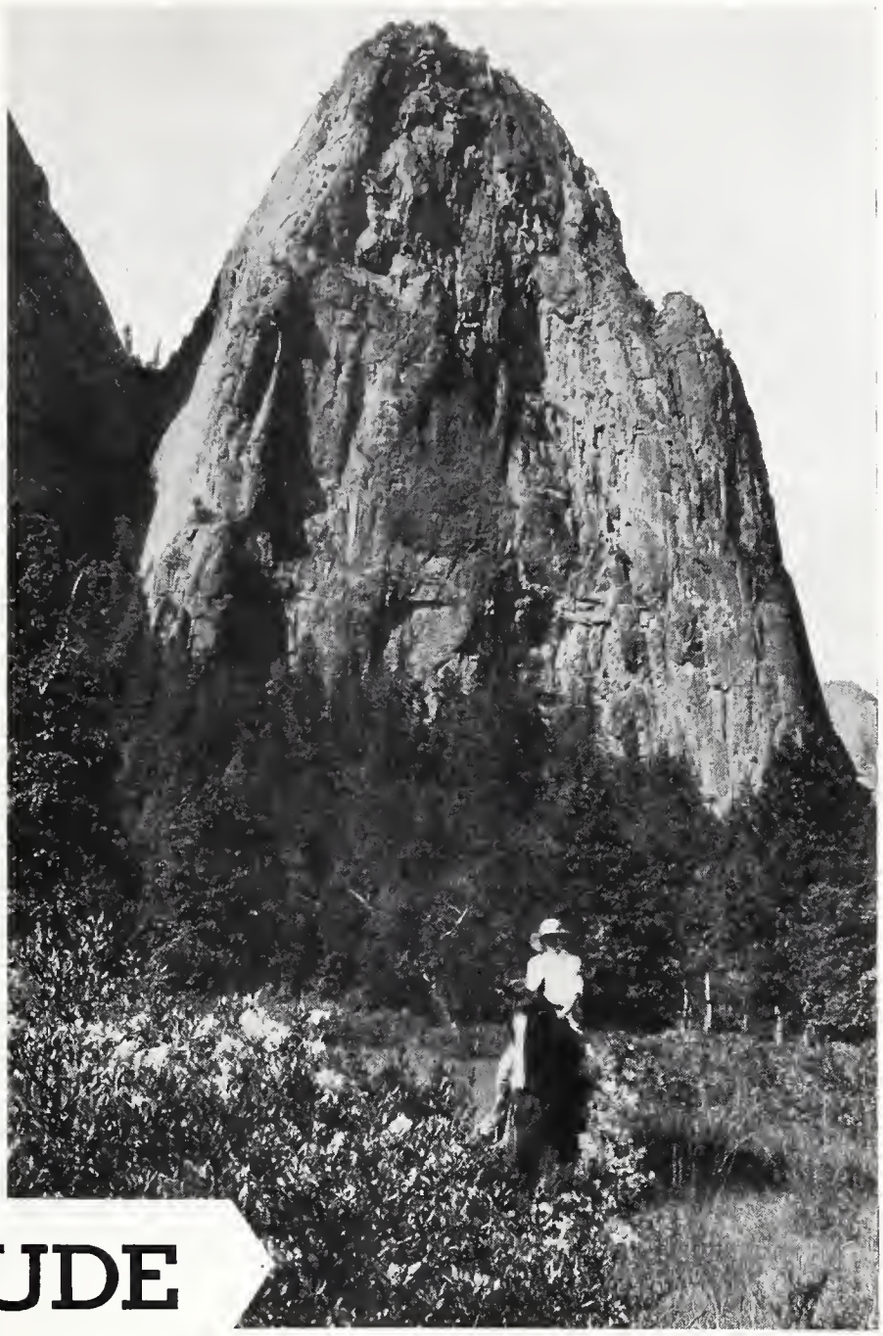
"James W. Davidson, 53, inspector for the State Board of Medical Examiners for the last eight years, died suddenly at his home yesterday from a heart attack. He was a prominent figure in the state agency and handled many important cases involving infractions of the Medical Practice Act, under direction of Dr. Charles B. Pinkham, veteran secretary of the Board. Davidson is survived by his widow, two daughters and a son." (San Francisco *Chronicle,* April 9, 1935.)

"The Assembly Public Health and Quarantine Committee last night tabled Assembly Bill 946 by Reaves, which would have amended the Chiropractic Act. . . ." (Sacramento *Bee,* April 11, 1935.)

"A compulsory State System of Health Insurance is recommended in the report of a Special Interim Investigating Committee, which was filed with the Senate today. The report will be followed with legislation to carry out recommendations. (Senate Bill 454, amended April 15, 1935). The plan calls for a State Commission of five members (three laymen and two physicians 'who have held the degree of Doctor of Medicine for not less than ten years') appointed by the Governor and confirmed by the Senate, to administer a health insurance fund, to be raised by payroll deductions. . . . The amount paid for each individual covered, would be approximately one per cent of the salary paid. Employers would be authorized to make deductions for the cost of coverage from the salaries of employees. . . . The plan would apply to all em-

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, Page 20)



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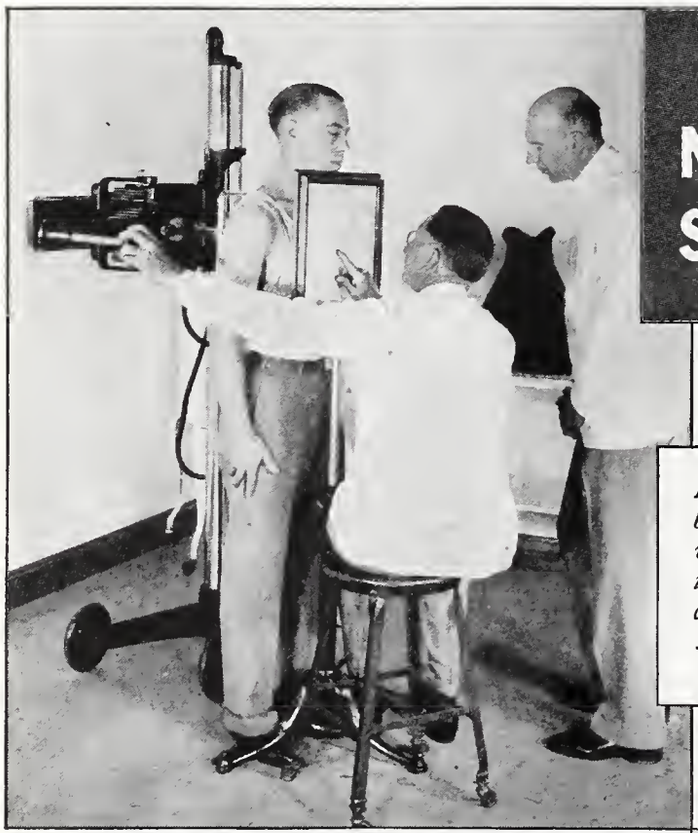
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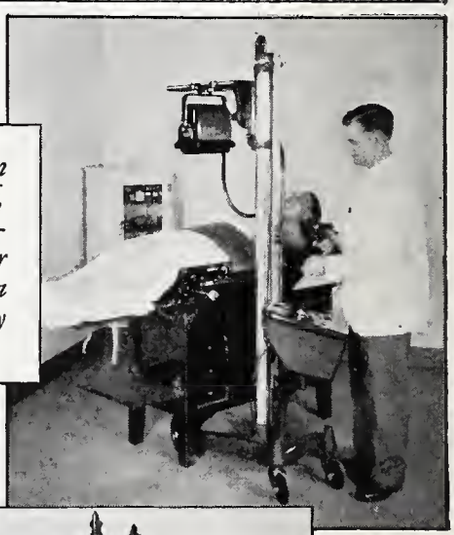
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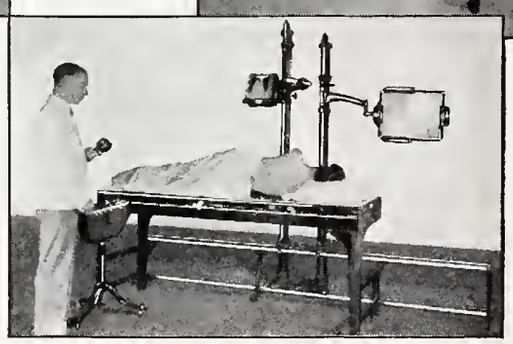
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(Continued from Page 29)

In addition to the 2,798 motor-vehicle deaths in public places, shown above, there were fourteen fatalities involving motor vehicles in homes and work places, making a grand total of 2,812 motor-vehicle deaths. Of this grand total, 1,456 were of persons gainfully employed at the time of the accident.

As usual, falls caused most deaths in the homes—662 out of a total of 1,292 home accidental deaths. It is interesting to note that 505 of these 662 deaths were in individuals sixty-five years of age and over. Out of forty-eight deaths due to mechanical suffocation, thirty-two were in children under four years of age.

By age groups, the 5,566 accidental deaths that occurred last year may be classified as follows:

Under 4 years	263
5-14 years	327
15-24 years	709
25-64 years	3,044
65 and over	1,223

Vital Statistics Index Project.—Through the assistance of a small group of typists provided through the use of Emergency Relief funds, work has been continued upon transferring names from the antiquated book index to a card index. More than one year of names registered in the book index has been transferred to cards, and it is hoped that this project may be continued indefinitely in order that the card index may be made complete for the years now covered by the inadequate book system.* . . .

Sacramento, April 5, 1935.

* From the office of the State Registrar of Vital Statistics.

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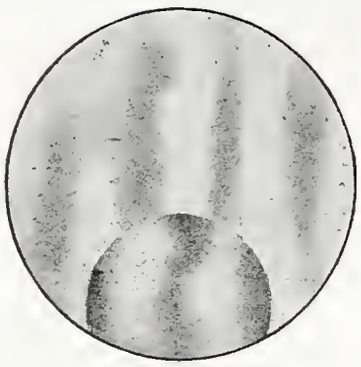
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JUNE · 1935

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Selective Diets in Hospitals.—The experiences with a uniform diet for most patients in hospitals have not been universally satisfactory. In some institutions of Berlin an experiment has been made with an à la carte service, which permits the patients to choose the food they desire or which is prescribed. The results of this experiment are considered satisfactory; for example, in the Virchow Hospital, which has had a longer experience with the new system than some of the other institutions now using it. On an average, this hospital serves meals to 2,400 persons daily, including physicians and hospital personnel. Of this number, from 1,400 to 1,600 persons are served diets I or II, which permit the use of all foods, except possibly a few of the vegetables that are hard to digest. Diets III and IIIa presuppose a certain amount of selection. The old plan of serving uniform meals to all patients gave rise to many complaints. At first the experiment was tried of serving the tuberculous patients, who are particular about their food, a selective diet, allowing them the choice of one or two articles. The complaints in this department ceased immediately. The experiment was then tried in other departments with equal success. Hence the new system was extended to all departments, and at the same time the number of meals at which a selective diet was permitted was extended to three a day. No complaints have developed since the introduction of the new system. There is no doubt that a diet satisfactory to the patients contributes to their recovery and influences their general well-being. This selective system makes it possible to take some account of local peculiarities and special dishes, which are very marked in many parts of Germany. With the former uniform diet, menus calling for large amounts of meat were very expensive. After introduction of the selective diet there was no difficulty in offering a diet rich in meats, for it was found in a short time that the selective diet entails much less expense than the uniform diet, for which fact several reasons may be assigned. Principally, with the introduction of the selective diet, the expensive system of zulagen (certain side dishes) was abolished. Formerly the uniform diet was supplemented, if desired, by side dishes in the form of sweets, desserts, fruit, and the like, in order to give more variety to the meal. This system, however, added a great deal to the general expense. Now the patients have accepted the discontinuance of the side dishes as a system without complaint. Another source of economy is the fact that, under the new system, certain cheaper foods of high quality can be served more frequently than under the old system, since the patients do not need to select them unless they desire. —Berlin News Letter, *Journal of the American Medical Association.*

Replace Slum Shanties with Modern Homes.—The slum district of Vincennes, Indiana, has been successfully razed, and the families, which had been living in lean-to shacks, goods-boxes and hovels, have been moved into clean brick dwellings erected by the Vincennes Social Welfare Foundation, according to an article on housing written by George R. McCormack.

Not only was the slum district, with the hazards of extremely unsanitary conditions and rat bites, a menace to its own citizens, but it was considered unhealthful for those in the city who had to come in contact with these people.

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BOOKS RECEIVED

(Continued from Page 11)

authority of Naval Appropriation Act for 1934, approved March 3, 1933. Vol. XXXIII, April, 1935, No. 2. Paper. Pp. 142. Price 25 cents. Washington: Government Printing Office, 1935.

State Hospitals in the Depression. A Survey of the Effects of the Economic Crisis on the Operation of Institutions for the Mentally Ill in the United States. Conducted by the National Committee for Mental Hygiene. Report prepared by Paul O. Komora, Associate Secretary, Assisted by Mary Augusta Clark, Statistician and Ralph A. Pierson, Research Assistant. Paper. Pp. 126. New York: The National Committee for Mental Hygiene, Inc., 1934.

The Modern Method of Birth Control. By Thurston Scott Welton, M. D., F. A. C. S., Editor of the American Journal of Surgery. Cloth. Pp. 168. Price $3 net. New York: Walter J. Black, Inc., 1935.

Economic Problems of Medicine. By A. C. Christie, M. S., M. D., Professor of Clinical Radiology, Georgetown University Medical School; President, Fifth International Congress of Radiology; Formerly President of the Medical Society of the District of Columbia, the American Roentgen Ray Society, the American College of Radiology and Member of the Committee on the Costs of Medical Care. Cloth. Pp. 242. Price, $2. New York: The Macmillan Company, 1935.

TWENTY-FIVE YEARS AGO

(Continued from Page 496)

From an article on "An Address, Delivered at the Fortieth Annual Meeting of the Medical Society of the State of California, Held in Sacramento" by James H. Parkinson, President, Sacramento.

The presidential address, like the beard of the oyster, seems an inevitable concomitant of our annual meetings. I am far from implying that it is a useless appendage, for many excellent papers have been presented to this Society. . . .

It is not my purpose nor my intention to present a formal address, but rather to bring before you as briefly as possible an urgent question or a point of view, as you may regard it.

"The Physician in His Relation to Public Life."—By "public life" I do not necessarily mean political activity, though in our country the terms seem almost synonymous, nor would I exclude this branch or phase of the question which more or less entwines itself with my original proposition. I mean more directly or more cogently the association with public movements, the leadership in those directly within our sphere, an activity in all matters of public health, an insistence upon measures and steps in relation to preventive medicine in which the welfare of all the people is concerned. . . .

What is the result? We, as a profession, do not occupy in public affairs the position we should justly fill, while civic, state and national public life all suffer from this torpor of inactivity. Nor is this canker of desuetude confined to the United States, for, along parallel lines, Great Britain and other countries have blundered with ourselves in failing to recognize the enormous potential for good that a somnolent profession contained. . . .

There is no profession or calling today—I make no exceptions—that stands closer to the people than medicine. No profession is less tainted with the suspicion of graft or of selfishness. The universal benefit of medicine "to every man according to his needs," the enormous charity of the profession, its constant efforts to prevent disease, are admitted and recognized. The field is ripe, the profession is becoming organized, the time for action is *now*.

Let me, in conclusion, repeat the text of my remarks, "The Physician in His Relation to Public Life," as I urge you to higher deeds. Let every man in his own community and in his own sphere deal

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with his people as he finds them. Let him but preach the doctrine of scientific medicine and of sanitation in all seasons. Let the leaders in our profession, when occasion demands, unite to demonstrate a position or to enforce a truth.

Then, backed by an organized profession, is it but a dream? Nay, will it not become a reality that medicine with its ever-growing knowledge in a godlike calling will shine with increasing effulgence until like a great sun it will illuminate the dark corners of defective sanitation, therapeutic ignorance and medical superstition, throughout the world.

Report of the Secretary.— . . . It was just ten years ago, in 1900, that I retired as secretary and Dr. George H. Evans was elected; at the meeting that year the matter of reorganizing the Society was favorably discussed, but no action was taken. There were something like 250 members.

In 1901, here in Sacramento where we are meeting today, a committee was appointed to draw up a constitution and by-laws along the lines of our present document. . . .

In 1902 a new constitution and by-laws were adopted and the present plan of basing membership upon the county society as the unit was adopted. The Council was also authorized to establish a journal if they saw fit. This proposition was discussed at several meetings of the Council, and in August it was finally decided to undertake it; I was requested by the Council to take the editorial control and begin the publication of the journal. The first number was issued in November of that year and contained pitifully few advertisements. . . .

In 1903 Doctor Evans reported that thirteen county societies had affiliated and that four had been organized for that purpose, representing 955 members; there were also 141 other members of various classes. It was apparent that the plan of organization needed considerable adjustment, so a committee was appointed to draw up a new document, of which committee I was secretary.

In 1904 Doctor Evans reported that fourteen new county societies had been formed, giving a membership in county societies of 1,446 and a total membership of 1,553. At this session the present constitution and by-laws were adopted. The secretary, Doctor Evans, again, and most emphatically, called attention to the value of the *Journal* in the work of prosecuting organization and keeping members in touch. It is not possible to give the exact financial condition, as the accounts were subsequently destroyed and the published reports are merely fragmentary. However, it

(Continued on Next Page)

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In 1909, April 15, we had 1,858 members; on the 31st of December we had 1,954 members. . . .

It is my pleasure to report to you that on the 1st of April we had but two items of indebtedness (aside from interest): $1,600 in notes, and a bill of $413.65 for a consignment of paper just received and unused; a total of $2,013.65. At the same time we had cash on hand, $3,135.02, or a surplus, if our affairs were wound up, and without allowing anything for office fixtures, of $1,121.37. . . .

Respectfully submitted,

Philip Mills Jones,
Secretary.

Report of the Council.

To the President and Members of the House of Delegates.— . . . The most important action taken by the Council during the year was that of establishing malpractice defense for the members of the Society, which was done at the meeting of June 24, 1909, such defense to take effect July 1, 1909. This action was taken under the authorization of the House of Delegates at the last annual meeting, and it is now the duty of this present House of Delegates to confirm or reject the plan adopted by the Council. . . .

TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

was not good. The Publication Committee reported a probable loss on the *Journal* for the next year of some $1,825, and there was a considerable debt already accrued. At this meeting, Doctor Evans gave up the secretaryship and I was elected his successor. . . .

In April, 1906, there were reported thirty-five affiliated societies with a total membership of 1,777. . . . The next day after these reports were made, we lost everything we had in the world except the books and accounts from May, 1905, to date. . . .

In 1907 the president reported that the Society had lost, through the fire and its consequences, $3,707.19. . . .

In 1908 the president reported that we had 1,817 members and had lost 7 per cent of our membership; he urged renewed activity in the matter of organization. . . .

That the situation may be brought out with the fewest words: First, the relative proportion of medical men to population is greater in this State than in any other place in the world. In cities like Los Angeles and San Francisco, a doctor to 250 people; the average for the whole State is one physician to about 450 of population, and in no portion of the State does there seem to be a ratio coming anywhere near what prevails in other states and in other countries. But heretofore the profession has enjoyed fair remuneration for services, thus compensating in a degree for the paucity of material. Recently, however, there has developed in various places an aggravating practice in contract service that eliminates a large percentage of the population from the ordinary honest practitioner. The evil complained of is not confined to one section, but is worse in some places than in others. . . .

(Continued on Page 18)



The "Continental" Breakfast is not suitable for a growing child

In far too many homes, a breakfast of a roll and a cup of coffee is the fare for children as well as adults. Woefully deficient in vitamins and minerals, such a meal furnishes little more than a small amount of calories. A dish of Pablum and milk, however, is just as easily prepared as a "continental breakfast," but furnishes a variety of minerals (calcium, phosphorus, iron, and copper) and vitamins (A, B, G, and E) not found so abundantly in any other cereal or breadstuff.

The addition of a glass of orange juice and one Mead's Capsule of Viosterol in Halibut Liver Oil can easily build up this simple breakfast into a nourishing meal for the children of the family as well as the adult members. It is within the physician's province to inquire into and advise upon such matters, especially since Mead Products are never advertised to the public. *Servamus Fidem*, "We Are Keeping the Faith."

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

From an article on "A Report of the Last Meeting of the Council on Medical Education of the American Medical Association, with Comparisons of Conditions Now Existing in California" by W. Jarvis Barlow, A.B., M.D., Los Angeles.

Medical Education.—The meeting of the Council on Medical Education of the American Medical Association, held in Chicago February 28 to March 2, 1910, suggested the following scheme for the ideal course that should constitute the study of modern medicine: . . .

Taking such data as a basis for present conditions and comparing the reports of the deans with the report adopted by the Council, it shows to what extent medical education in California conforms to that in other states, using the outlines previously given:

1. *Preliminary Education.*

(*a*) "Four years' course in high schools." This is required by all schools in the State.

(*b*) "At least one year in pre-medical sciences." This is required by three regular schools only.

2. *Professional Education.*

(*a*) "A four years' course in the medical school." . . .

From an article on "Statistics from Medical Schools in the State of California." Compiled by W. Jarvis Barlow, A.B., M.D., Los Angeles.

Regular	6
Homeopathic	1
Eclectic (no reply)	1
Osteopathic	2

Teaching covers four years in all schools except the osteopathic, which teach three years.

Entrance requirements:

Three years' college work, 1 R.
Two years' college work, 2 R.
High school diploma or equivalent, 3 R; 1 H; 2 O; 1 E.

Number of students attending, 1908-1909:

Regulars	341
Homeopathic	24
Eclectic	9
Osteopathic	389

Diplomas granted, 1908-1909:

Regulars	66
Homeopathic	7
Eclectics	4
Osteopaths	78

Licentiates of California State Board, 1908-1909:

Regulars	77
Homeopathic	11
Eclectics	1
Osteopaths	29

Report of the Editor:

. . . The editor will not touch upon this territory at all, except to state that there seem to be two entirely different views of the *Journal* in regard to its value or worthlessness. . . .

In several previous reports the editor has called attention to the fact that the *Journal* is just exactly what you gentlemen and the other members of the Society make it. If your papers are poor in quality, by just that much does the tone of the *Journal* fall; if they are good papers, showing good, thorough and careful work, by that much has the scientific tone and quality of the *Journal* been improved. . . .

(Continued on Page 20)



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It is suggested that Trichlorethylene be given further experimental trial in well controlled clinics for analgesia in such conditions as migraine, maxillary neuritis, mandibular neuritis, neoplasm of the upper respiratory and pharyngeal tract, painful contractures in the temporo-maxillary region, and in such other analogous conditions.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

Furthermore, the editor is convinced that a large majority of our members and readers are physicians practicing busily among sick people who want to be relieved and as soon as possible, rather than pure scientific investigators or abstruse diagnosticians. It is quite as necessary to get hints upon how best to treat one's patients as it is to learn the very latest scientific advance of a purely speculative character that may have occurred in some foreign land. The editor believes that the *Journal* is for the many and not for the few in either extreme, and he has steadfastly adhered to that policy from the beginning. If the Society wishes that policy changed, it must say so in no uncertain tones. . . .

Phillip Mills Jones, Editor.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 496)

pending a federal hearing Saturday, according to press dispatches from the Arizona city. The doctor practiced medicine here for several years, leaving to establish offices in Brawley and West Moreland a year ago. His wife, Elsie Jean, who was also his office nurse, was arrested also, but was released in custody of her attorney, according to the news story. A federal narcotic agent is said to have bought 'dope' from the doctor for several weeks and had trapped Long with the money in his hands when he had made a personal delivery in Phoenix." (Calapatria *Herald,* April 11, 1935.)

"Pleading guilty to charges of issuing false prescriptions for narcotics, Dr. F. T. Bantum, Vernon Avenue physician, was given a three months' jail term yesterday by Federal Judge Harry A. Hollzer. . . ." (Los Angeles *Illustrated Daily News,* April 25, 1935.)

"Foremost on the list of diversified rackets, all like tentacles of an octopus, bleeding the victim of his money, is the ear-phone racket. Ear-phone advertising would convince you that so and so, a device attached to a door knob, would enable that inanimate object to hear like a normal human being. Such deceptive advertising is nothing short of fraud. Persons with slightly impaired hearing are often aided by amplifying devices, but those whose hearing apparatus has been destroyed or never functioned since birth, cannot be aided by anything, with the possible exception of a divine miracle, yet it is mostly to this hopeless class that these ear-phone racketeers cater and attempt to mislead. . . . Another popular method of extortion still widely practiced is the herb 'medicine oil' and secret recipe racket. Some charlatan with an oily tongue and some bottle of anointed and scented liquid of doubtful value is to be found in every city of size in this country. He sells a 'cure all ills' concoction. Eager parents, ambitious for the welfare of their children, have no scruples against trying something new that promises relief. . . . Many people fall easy dupes and after a low priced first trial treatment are induced, mostly through a comprehensive sales talk, which appeals more to the imagination than to good common sense, to keep on with the treatments, hoping for a cure, until their money or their patience is exhausted. . . ." (Sacramento *Union,* April 16, 1935.)

"A drive upon quacks and fly-by-night operators was pledged today by William G. Bonelli of Los Angeles, who arrived here to assume his duties as the State Director of Professional and Vocational

(Continued on Page 22)



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 20)

Standards. . . . The new director is no stranger to Sacramento, having served in the State Assembly and, during the war, in the Army Air Corps at Mather Field. . . ." (Sacramento *Bee,* April 15, 1935.)

"'A superabundance of cultists and quacks' was blamed yesterday by Dr. Morris Fishbein, editor of *The Journal of the American Medical Association,* for the 'unsettled condition of Pacific Coast medical affairs.' 'California is in the midst of more involved and extraordinary medical legislation than any other state in the Union,' Doctor Fishbein said. 'There are pending bills on sickness insurance, dental advertising, right of corporations to practice medicine and the possibility of opening county hospitals to all comers. These represent the state legislature's attempt to cope with California's unique medical conditions. . . .'" (Sacramento *Bee,* April 13, 1935.)

"Dr. Francis D. Coltrin of Fullerton, recently found guilty of second-degree murder and performing an illegal operation, was refused probation yesterday by Superior Judge H. G. Ames." (Orange *News,* April 27, 1935.)

"Medical products, advertised over the radio contrary to federal regulations, today were the object of a clean-up drive launched by the California State Medical Association. . . ." (Hollywood *Citizen News,* April 18, 1935.)

"A bill tightening the State chiropody law, sponsored by Assemblyman Fisher and backed by Cali-

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fornia chiropodists, last night was killed in committee after representatives of shoe dealers and corrective foot appliance manufacturers protested its enactment would prevent them from advising customers what type of shoe or appliance should be worn." (Oakland *Tribune,* April 23, 1935.)

Reports relate that Cecil E. Bowlby on May 8, 1935, in the Municipal Court at Los Angeles pleaded guilty to violation of the Medical Practice Act and was sentenced to 180 days in the county jail, which sentence was suspended, and he was placed on probation.

Records indicate that on February 22, 1935, a remittitur and opinion was filed which affirmed the judgment rendered by the court in Los Angeles, June 25, 1934, finding Samuel D. Collins, chiropractor, guilty of asserted criminal abortion, following which he was sentenced to San Quentin, which sentence was modified and he was placed on probation for five years, during which time he was "not to practice chiropractic nor any branch thereof, or maintain signs to that effect" and was also to pay a fine of $300 within the year.

The records show that N. Z. Garess pleaded guilty on May 6 in the Municipal Court of Los Angeles to a charge of violation of the Medical Practice Act and was sentenced to serve 180 days in the county jail, sentence suspended.

L. V. Stevens was reported to have pleaded guilty April 15, 1935, at Chula Vista to a charge of violation of the Medical Practice Act and was sentenced to pay

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

a fine of $300 or serve one day in jail for each $5 thereof. Two hundred and fifty dollars of the fine was suspended on condition that $50 be paid and the further condition that he desist from further violation of the Medical Practice Act. He paid the $50.

Attention of the Board of Medical Examiners was recently directed to another eyesight swindle perpetrated in Boulder, Colorado. These swindlers obtained a $500 bank draft from their victim, which draft was reported cashed by a pawnbroker in Portland, Oregon.

Records show that George Floden on April 1 was sentenced in the Municipal Court of Los Angeles to pay a fine of $50 or serve twenty-five days in the city jail on a charge of violation of Section 17 of the Medical Practice Act. Sentence was suspended and he was placed on probation.

Investigation reports relate that on April 11, 1935, Charles G. Joseph was sentenced in the Police Court of Glendale to pay a fine of $600 or serve 180 days in the county jail on a charge of violation of the Medical Practice Act. Three hundred dollars of the fine was suspended and three hundred dollars paid. It is related that the fact that Joseph reimbursed a number of persons in the vicinity of Glendale and Burbank, whom he had defrauded by the fake eye radium water operation, probably had something to do with the light sentence imposed. Local officers evidently regarded it more important for the aged and almost blind victims to recover their losses than it would be to send Joseph to jail, as no complaint was filed except the one filed by the Board of Medical Examiners, charging Joseph with violation of Section 17 of the Medical Practice Act. Our investigator expressed his opinion that Joseph should be in prison. We agree that all these eyesight swindlers deserve severe prison sentences.

Records of Longevity.—For the twentieth year, Mr. C. B. Gabb has reviewed the longevity figures recorded in the *Times* during the past twelve months. On the front page of the *Times* during 1934 the deaths of 460 persons 90 years old and over have been recorded. Of these, 127 were men and 333 women. Of the latter, 207 were married. The total number of nonogenarians who died in the last twenty years was 7,305, of whom the majority were married women, giving the yearly average of 365. The centenarians who died in 1934 numbered eleven, against twenty in 1933. Only one of the eleven was a man, and six of the women were married. The senior was a married woman, aged 105. In Ireland the burial of Mrs. Catherine Buckland, aged 123, in Ballycommon churchyard, North Offaley, King's County, was recorded. Edward Cooper, born in Dublin, September 18, 1818, died in California. He had lived in the United States eighty years, having migrated in the early gold rush. Franz Baldasti, believed to be the oldest man in Austria, who recently carried off first prize at a village dancing competition, died at 110. Mrs. Maria Greenwich, the oldest woman in western Canada, died at the age of 109 at Edmonton, Alberta. A woman of the same age, Mrs. Scariffe, died at Glengarry, Australia. William Freeman, aged 104, the last Crimean veteran in Australia, died at 104, and another Crimean veteran, James Crawford, died at the same age in New Zealand. Frau Maria Schoepperle, the oldest woman in Germany, died in Barder at the age of 106. Mrs. Trainer died at Newry, Ireland, at the same age.



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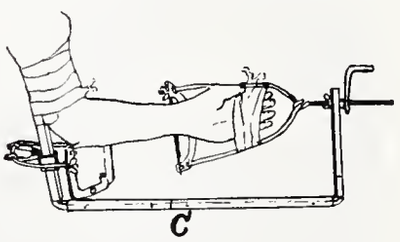


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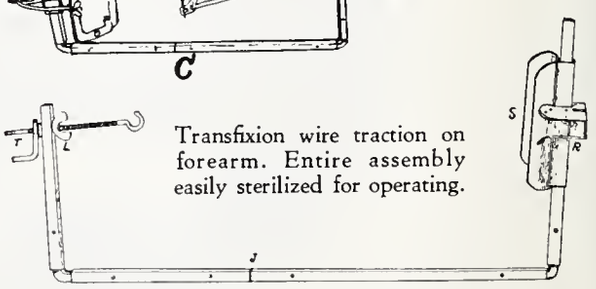
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Food Superstitions Spring from Faulty Reasoning. Food fads are the result of faulty reasoning according to Dr. Harry Gauss. Food fads are not new, but are as old as civilization itself. They are the children of well-meaning but misguided intellects. From the fad introduced by the cult which believed that a teaspoonful of sand eaten every day aided digestion to those fads observed in the work-a-day world among persons who will not eat fish and milk during the same meal and those who believe that milk and orange juice are an unhealthful mixture, these fads have no scientific basis.

One meets faddists who protest against the eating of protein and starch in the same meal, and there are those who brand as dullards all persons who eat meat. They declare that meat-eating races are more savage than vegetarian races. Such theories are exploded by the fact that the Anglo-Saxons are reputed to be great meat eaters, and they have not proved slow or plodding in establishing their positions in worldly affairs. The Eskimos, the most carnivorous people alive today, are a most peace-loving people.

A Salaried Service of Municipal Midwives.—The Joint Council of Midwifery, which is representative of the important medical nursing societies, has issued a report on the desirability of establishing a salaried service of midwives, under the local authority in all areas not already served by salaried midwives. The cost of the service, as far as practicable, is to be met by fees charged by the authority of local voluntary organization for the services of the midwife. The council holds that the nursing in every maternity case should be conducted by a qualified midwife and that unqualified persons should not be permitted to nurse in maternity cases for gain. It should be the duty of the local authority to provide that midwives are avail-

(Continued on Page 28)

A System for the

Collection of Fees

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Our bookkeeper fails to find your account settled on our books. Please help him out.



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This Account has no doubt escaped your notice. Will you please favor us with a remittance by return mail and oblige?

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Our records show that several statements and reminders have been sent you regarding the enclosed statement.

If your circumstances have made it impossible for you to pay the amount due, kindly write us promptly to that effect. Our office will then endeavor to extend all possible courtesies.

You appreciate, we are sure, that physicians, like other citizens, must pay their bills promptly. They can only do so, however, when their own clients in turn pay them promptly for such professional services as may have been rendered.

A check to cover your account, which is now considerably overdue, will be appreciated.

Final Notice

In practically all businesses the custom which is generally followed with overdue accounts is to send such to a collecting agency.

Our bookkeeper has nothing in the records of the office to show when you intend to pay the enclosed account. Perhaps the previous statements and reminders may have been overlooked or ignored.

Following the rule of this office, this overdue account will be sent to the collecting agency within ten days if arrangements for its settlement are not made prior to that time.

This collection bureau method is disagreeable to us; and we believe, also to you. By promptly sending your check all this can be avoided.

When an account is sent to the collecting agency that organization takes full charge of it thereafter.

In the September, 1927, issue of California and Western Medicine, page 398, appeared an article relating to the "collection of fees." Following this publication so many orders were received by us for printing the series of gum stickers and notices, we decided to print and stock the series in large quantities.

That we were justified in this decision is evidenced by the fact that thousands of these notices have been used by the medical profession of California. They *get* results. Many users of the system have reordered the series.

You, too, can profit by using the system for your delinquent accounts. They are inexpensive and easy to use.

The prices, including postage, are:

250	$ 6.75
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Laryngoscope, 1935, XLV, 149-154★

SEE ALSO
Pharmacology of Inflammation: III. Influence of hygroscopic agents on irritation from cigarette smoke.
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

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These Kip products are not advertised to the laity. Available through selected surgical supply houses and drug jobbers. For further technical information address Mona E. Bettin (M. D.), Pathological Laboratories, Roosevelt Building, Los Angeles, or

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* *Reg. U. S. Pat. Off.*

(Continued from Page 26)

able as maternity nurses for any patient who has engaged a physician for her confinement but is unable to afford this additional expense. But it is not intended to interfere with the continuance in practice of independent midwives. Midwives entering this municipal service should receive adequate pay, allowances and pension rights and be accorded the same status in every respect as health visitors. The average number of cases that a midwife would be expected to attend should not exceed eighty a year. After this new act has come into operation the local authority should require that midwives in independent practice who, from age or physical or mental infirmity are unable to carry out satisfactorily midwifery practice, retire on receiving an adequate pension. Every midwife should be required to take a refresher course, including, if necessary, two months' residence in a training institution, at intervals not exceeding seven years.

THE INADEQUACY OF THE PRESENT REMUNERATION OF MIDWIVES

Owing to the large number of midwives in practice and the necessarily small fees paid by poor persons, the remuneration of midwives is entirely inadequate. The estimated number of salaried midwives now is 6,255 and of independent midwives 3,187. In 1929 a government committee, which reported on the training and employment of midwives, gave the average number of cases attended per midwife as slightly over forty and suggested that the average gross earnings varied from $450 to $600 a year. It is estimated that the position is much worse today, the average being estimated at $400 and in some cases as low as $250. Assuming that in future a midwife will attend every case, whether a physician is in charge or not, the number of municipal midwives likely to be required is estimated at 4,000. In addition, part time midwives or district nurses would probably have to be retained by



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means of a subsidy in semi-rural areas not covered by nursing associations.—London News Letter, *Journal of the American Medical Association.*

Socialist Politicians and Misleading Propaganda.—The attempt of a woman's organization, "The Maternal Mortality Committee," to represent maternal mortality as connected with malnutrition due to unemployment was reported in *The Journal*, December 8, 1934, page 1787. The members of the committee passed a resolution stating that they were deeply impressed by the reports of malnutrition among married women in areas of prolonged unemployment, and they sent a deputation to the minister of health. He replied that there was no evidence showing a close relation between malnutrition and the maternal mortality rate. Of the deaths examined, at least one-half occurred among well-to-do people, and it was significant that the maternal death rate for 1933 in such a depressed area as Durham was no higher than in the relatively prosperous county of Middlesex. Nevertheless the conditions in the depressed area were such as to give rise to anxiety and the position was receiving the close attention of the administration. Local authorities had been urged to make full use of their powers, in appropriate cases, to supply milk and other foods to expectant and nursing mothers. Attention was being directed to improving the antenatal service, insuring the availability of a trained midwife able for all confinements, the provision of maternity beds for complicated cases and patients with unsuitable home conditions, facilities for isolation of septic cases, and providing the services of a consultant in difficult cases.

It has been shown by the report of the chief medical officer of the ministry of health that the general health of the population is well maintained in spite of economic difficulties. Indeed, he stated that the nutrition of the English people is better today than it has been at any period of which there are records. The infant mortality rate for the quarter ended last September was the lowest ever recorded, being forty-five per thousand live births and seven below the average of the ten preceding third quarters of the year. Yet socialist politicians are constantly representing the people as suffering in health because the government or local authorities do not give more away. The fact is that the unemployed in this country are better off than those in full work in many European countries. But however much the state does in the way of relief, socialist politicians clamor for more and use misleading propaganda.—London News Letter.

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It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is *marked* drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

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By PROF. SYDNEY A. TIBBETTS, *Berkeley*

MANGANESE	1.3 parts per million
IRON	12.5 parts per million
CALCIUM	173.3 parts per million
MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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(Continued on Next Page)

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(Continued from Preceding Page)

available at all times. This service will be described in a future letter. In smaller cities such as Bordeaux in the south of France, an effort has been made to utilize the blood of donors (universal group), which has been collected in flasks and kept liquid with the aid of a 10 per cent sodium citrate solution.

Jeanneny and Vieroz, at the December 5, 1934, meeting of the National Surgical Society, reported the details of how such blood is kept in a refrigerator at 2 Centigrade (35.6 Fahrenheit). The blood can be utilized only during a period of twenty days after being placed in the refrigerator.

In only six of the seventy cases were any reactions observed, in the form of a severe chill with slight fever (one case), slight chills without fever (four cases) and a feeling of paresthesia (one case). The simplicity of the technique of collecting the blood and its administration renders it available for city hospitals, where much time may be lost in making the various tests, especially those for syphilis.

Examination of the refrigerated blood reveals no changes in its components.—Paris News Letter.

Marriages Show Marked Increase.—More marriages were recorded in California in the year 1934 than during any single year since 1927. There were 51,924 weddings registered last year as compared with 46,484 such events in 1933. This represents an increase of 5,440 legal matings, or 11.7 per cent increase over the number recorded during 1933. In some counties, the percentage of increase over the preceding year was as high as 100 per cent. As a matter of fact, more marriages were performed in 1934 than during the preceding year in all but six counties of the State, and in those six counties the differences were negligible. In December, 1934, more marriages were performed in the State than during any December in the history of California.

During recent years, sharp decreases in the number of marriages have occurred in the larger centers of population while increases have occurred generally in the rural counties. In 1934, however, the increased number of marriages in the larger cities is most conspicuous, and the rural counties, almost without exception, continue to record more marriages. Because of the greatly increased numbers of marriages that occurred in December of last year, it is assumed that the year 1935 will show continued increases. Since the number of marriages performed in any community is regarded generally as an index to prosperity, it would appear that economic conditions in California are decidedly better than they have been at any time during recent years.

Following are the numbers of marriages registered in California counties during 1933 and 1934, and also the numbers of marriages performed, by months, during the years 1926 to 1934:

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Marriages—1934 and 1933, by Counties

County	*1934*	*1933*
California	51,924	46,484
Alameda	3,708	3,087
Alpine		
Amador	30	43
Butte	196	203
Calaveras	27	20
Colusa	37	37
Contra Costa	559	548
Del Norte	69	40
El Dorado	36	30
Fresno	1,215	942
Glenn	55	59
Humboldt	364	217
Imperial	229	174
Inyo	26	21
Kern	846	602
Kings	245	203
Lake	61	72
Lassen	34	26
Los Angeles	18,390	16,810
Madera	165	126
Marin	297	296
Mariposa	47	32
Mendocino	158	118
Merced	298	254
Modoc	35	37
Mono	4	4
Monterey	552	514
Napa	253	237
Nevada	70	52
Orange	4,019	3,938
Placer	100	83
Plumas	12	9
Riverside	1,247	1,189
Sacramento	992	829
San Benito	151	136
San Bernardino	1,293	1,128
San Diego	1,967	1,793
San Francisco	5,807	5,034
San Joaquin	799	690
San Luis Obispo	300	302
San Mateo	839	700
Santa Barbara	787	683
Santa Clara	1,443	1,337
Santa Cruz	514	462
Shasta	122	94
Sierra	3	1
Siskiyou	177	159
Solano	295	311
Sonoma	503	471
Stanislaus	464	401
Sutter	52	58
Tehama	92	84
Trinity	26	13
Tulare	605	521
Tuolumne	67	56
Ventura	1,036	993
Yolo	113	122
Yuba	93	83

Marriages, 1926 to 1934, Inclusive, by Months

	1934	*1933*	*1932*	*1931*	*1930*	*1929*	*1928*	*1927*	*1926*
Total	51,924	46,484	43,164	47,525	50,154	51,866	46,945	53,471	56,663
January	4,134	3,333	3,203	3,721	3,713	3,777	3,571	4,439	4,171
February	3,577	2,916	3,090	3,337	3,405	3,176	3,276	3,854	3,553
March	3,593	2,866	3,014	3,070	3,457	3,185	3,219	3,961	3,820
April	4,048	3,224	3,174	3,984	3,889	4,029	3,492	4,208	4,253
May	3,650	3,393	3,206	3,418	3,647	3,674	3,524	4,469	4,118
June	5,717	5,119	5,082	5,915	5,889	6,235	4,707	7,008	6,765
July	4,632	4,275	3,891	4,334	4,960	5,612	4,729	5,799	5,312
August	4,554	4,520	4,098	4,261	4,349	4,765	4,257	3,985	5,011
September	4,692	4,453	3,919	4,310	4,695	4,743	4,422	4,239	5,526
October	4,507	4,133	3,541	3,814	4,130	4,258	4,162	3,691	4,770
November	4,195	3,913	3,507	3,581	3,822	4,088	3,612	3,982	4,804
December	4,625	4,339	3,439	3,780	4,198	4,324	3,974	3,836	4,560

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ACCREDITED REPRESENTATIVE OF THE CALIFORNIA AND NEVADA MEDICAL ASSOCIATIONS

VOL. 42 JUNE, 1935 No. 6

ORGANIZED MEDICINE IN CALIFORNIA—SOME OF ITS PROBLEMS*

ADDRESS OF THE RETIRING PRESIDENT

By CLARENCE G. TOLAND, M.D.
Los Angeles

AS I stand before this assembly of representative physicians of California, the past year comes to me in retrospect, and the words of the Angel seem particularly appropriate, as when he said to St. John, "These are they which came up out of great tribulation."

OUR PROBLEMS ARE OLD PROBLEMS

We have faced, and are now facing, serious medical-social problems. These problems, however, that have come to our attention so suddenly are not in reality new, but have been gathering these many years. They are not, in general, peculiar to the medical profession, but are aspects of a massive social and economic movement which has grown to such dimensions that it can no longer escape our notice. As they apply to medicine they have not arisen because of any lack of public confidence in the ability of the medical profession.

The standards for entrance to medicine are the highest of any profession. They have repeatedly been raised to obtain men of the highest type in character and technical training, and we can be assured that in the future our places shall be filled with men of distinction.

We can inspect the medical roster of the past with complaisance. The physicians who have willingly offered their lives on the altar of unselfish and self-sacrificing service in the study of disease are legion. We are not boastful. We reverence those names and venerate the heritage they have left to us. We are proud of this tradition of service, and we resent any imputation of dereliction in our duty to the sick.

REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

The report of the Committee on the Costs of Medical Care, after its five years of study, has been considered by sociologists as a challenge to the medical profession; as an indictment of the present social organization for the care of the sick.

In reality, a detailed study of this report is not at all discouraging. When we consider that the 9.8 per cent of our people who, according to the report, receive no medical care, include all of those with disorders which, "wholly or in part disable an individual for one or more days," we realize then the minor nature of such illness. Thirty per cent of these were minor respiratory diseases. Hardly anyone consults a doctor for a cold, a sick headache or an attack of so-called lumbago.

The survey made in the State of California during the past year requires more careful scrutiny. Apparent inadequacy of medical care of the indigent for disabling illness was found in 20 per cent. Here, too, the definition of disabling sickness as any disorder interrupting the normal routine of life, would include a high percentage of colds, for which most people consult no physician.

MORBIDITY AND MORTALITY RATES IN THE UNITED STATES

One quite definite criterion as to the adequacy of medical care is the mortality and morbidity rates. Statistics of the League of Nations show that the United States had a lower general death rate, a lower infant death rate, and lower mortality and morbidity rates from diphtheria and tuberculosis in 1933 than any other first-class power for which data are available.

Mortality and morbidity rates have not increased during the depression; they have actually been lower. A study of economic crises for the last one hundred years shows that the total mortality figures, and the morbidity figures for tuberculosis, were definitely lower during the periods of depression than during periods of prosperity. These figures do not find their way into the speeches of the opponents of the medical profession who talk with pathos of the hundreds of thousands of cases of sickness needing medical attention during the past six years.

The health of the North American people is superior to that of any other country in the world, because the quality of medical service is better. The selection of Doctors Whipple, Minot, and Murphy as winners of the Nobel prize for the past year was a tribute not alone to the individual

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ability of the distinguished recipients, it was also a recognition of the excellence of American medicine.

RELATION OF THE WORLD'S ECONOMIC STRESS TO MODERN-DAY MEDICAL ECONOMIC PROBLEMS

The economic crisis has brought in its wake the present medical crisis. Lower incomes do not make medical care more costly, although it may seem relatively more costly. Lowered incomes make it more difficult to pay for medical care, but do not influence the actual costs.

It is an interesting commentary on the American sense of relative values that even during this depression more money is being spent on movies, cosmetics, and tobacco than is spent on medical care. The latter item includes such an extensive list as cost of physician, hospital, drugs (both useful and of the patent medicine type), that which is spent on practitioners other than physicians and surgeons, nursing costs, and the costs of dental service. Twice as much is spent on candy as on hospitals.

We are thus faced with a paradoxical situation in which the nation is able to meet the cost of luxuries, but not of necessities. We are apparently confronted by a dilemma of collective national improvidence rather than actual need. We say national, because individually we meet the many exceptions. Individually, the physician has always considered the sick as his responsibility, their care his life work.

The medical profession has never been indifferent to the welfare of the low-income classes. A very conservative estimate places the value of services donated by physicians of the United States to the care of the indigent and low-income groups, during the last few years, at about one million dollars a day; and almost without exception those institutions offering gratuitous services to these groups depend for their very existence upon freely given services of physicians.

THE RECORD OF THE MEDICAL PROFESSION

When we begin our attempt, therefore, at a solution of the problem of medical care, we may do so with no qualms of doubt as to whether we have properly performed our duties as the natural guardians of health. The abrupt crystallization of the whole problem is the result of the general depression, and nowhere is the consciousness of the existence of the problem more acute than in our own profession.

You are all well aware that from time to time critics, almost invariably laymen, have complained that the medical profession was too slow and backward in adopting new remedies and methods. These critics have complained that physicians were unwilling to take advantage of what appeared (to such critics) to be wonderful medical discoveries. But every one of you realize that, had the attitude of the profession been different, we would now be using a thousand specific cures for certain incurable diseases, all of which would have no effect, except to raise the patient's hopes and lower his financial reserve.

For centuries physicians have adhered to Saint Paul's aphorism, "Prove all things; hold fast to that which is good." This conservatism, this reluctance to apply, perhaps prematurely, apparent medical discoveries before their value has been thoroughly assayed, is often misunderstood by the public.

IS THE CRITICISM FROM LAY SOURCES JUSTIFIED?

Is it not possible, too, that our slowness to accept the various forms of social medicine which have been proposed from time to time—largely by people who know nothing whatever of medicine, and in the main smelling strongly of book-lined studies and the easy chair—arises from the same caution, the same unwillingness to experiment at the expense of the public, that characterized our unwillingness to accept Mr. Wilshire's magic "horse collar" as the answer to all therapeutic problems?

We are probably to blame for many medical misconceptions in the layman's mind. In the past he has been trained to feel that the best care can be obtained only from specialists. The employment of special procedures and special laboratory tests has educated him to feel that failure to employ such methods indicates inferior care. The plight of the general practitioner, until the last few years, has been an unenviable one.

MAJOR AND MINOR ILLNESSES

Eighty-five per cent of the conditions for which most patients consult doctors can be diagnosed and treated by a good general practitioner with only the amount of equipment he carries in his bag. In only 15 per cent are special tests needed. Any failure to provide 85 per cent of the sick with unneeded tests does not constitute inadequate medical care. We must, then, emphasize to the public mind the minor nature of this 85 per cent of the sickness.

The remaining 15 per cent of those sick form the group bearing the greatest medical cost, paying half of the money spent yearly for medical care.

This is the group which requires hospitalization, and suffers from the cost of sudden, unexpected sickness.

THE PRESENT-DAY SOCIAL UNREST

The present culmination of unrest is the result of certain basic social changes of the last several decades. There has been a trend of population to the cities, with a concomitant migration of physicians. There has been a marked drop in the rate of increase of the population. It is estimated that in a generation we shall have a stable population. The period of expansion in this country is apparently reaching its end.

HAS THE UNITED STATES MORE PHYSICIANS THAN IT NEEDS?

At the same time the number of physicians graduated yearly has increased steadily. In a period of accelerated population increase and of expansion, this increase could have been assimi-

lated. But present conditions forbid this; and this steady accretion can only serve to render more difficult a solution of the medical economic problem, already aggravated by the fact that the United States has twice as many physicians per unit of population as any of the leading countries of Europe.

Only last year, Dr. Walter L. Bierring, president of the American Medical Association, emphasized the importance of decreasing this plethora of physicians. In the past this was accomplished by raising the standards for entrance to medical schools; but even this requirement at present is inadequate.

CALIFORNIA'S MEDICAL ECONOMIC SURVEY

In California we have taken a step which may affect the status of every physician. For the first time in this country, representatives of the medical profession have conferred with a committee of the state legislature for the purpose of presenting a tentative plan for the care of the sick.

The action of the California Medical Association in suggesting legislation designed to spread the cost of medical care occurred only after long and earnest consideration.

Twenty-three hundred years ago a great physician pronounced a dictum which has lived through the ages as a guide for the doctor of medicine: "I will follow the system or regimen which, according to my ability and judgment, I consider for the benefit of my patients. With purity and with holiness I will pass my life and practice my art." This spirit that has guided us through the centuries has not vanished, and I am firm in my conviction that there never has been a time other than the present when the medical profession has adhered more rigidly to that oath.

MERITS AND DEFECTS OF INSURANCE PLANS

Our chief concern, as doctors, has been whether a plan for health insurance would or would not be for the benefit of the patient. Although the majority of the House of Delegates, at the special session held in Los Angeles on March 2 and 3, 1935, supported the plan for health insurance, that support fell far short of unanimity. Many are not convinced that such legislation will prove the best for the ultimate welfare of individual patients or the people in general. Such plans in other countries have failed in many particulars to provide satisfactory individual care.

Many also are not convinced that the science of medicine will flourish under a system of regimentation, and believe that the future health of any nation will always depend upon the scientific knowledge of the profession. Such knowledge is predicated upon a freedom of individual research, which may suffer badly under a regimen of mass medicine. It may or may not be significant that the outstanding medical discoveries of the last twenty years have come from our country, and not from any country under a system of general health insurance.

We all are convinced that the medical profession alone is qualified to lead in the development of any plans for an organized system of medical service.

This is an immutable principle to which each physician thinking of his patient's welfare is committed. It has been written by the physician into every consideration of any plan for the care of the sick. It is a fundamental safeguard to protect the patient from political exploitation. It must be the building-stone for any projected plan of medical care. Without it the relation of confident patient to conscientious doctor is destroyed, and the structure of ethical medicine will totter. We hold, as physicians, that the medical profession is the only body qualified, by training, to determine how medicine shall be practiced. No layman has ever been endowed with clairvoyant powers which enable him to differentiate an emergency such as a ruptured ulcer from a benign stomach ache. Nor can we trust such lay ability in a larger measure to manage the technical phases of medicine which require similar training and knowledge to administer.

In conferring with the legislature we have shown a spirit of willing coöperation. May we not hope that the response of the people, through the legislature, will be to respect the judgment of the medical profession, and to grant them the untrammelled leadership in any plan for medical service?

Any infringement of that fundamental principle will be met by the spirited resistance of the medical profession fighting, as always, to protect what we know are essential safeguards for the health of the people.

PHYSICIANS SHOULD BE INTERESTED IN CIVIL POLITICS

If the people demand such legislation, we shall not oppose nor hold aloof from it, but shall lead them in an attempt at an intelligent solution. The only possible solution, however, is by controlled experimentation, by trial and error. The next generation will be occupied with the problems of any plan to be adopted. We, as physicians, must coöperate as never before in a vigilant and stalwart defense against political interference, that the interests of the patient, and the rights and necessities of the sick, be not infringed upon.

During the past year the necessity of such a defense presented itself, and the inherent tendency of physicians to political disinterestedness underwent a change.

When a champion was needed to protect the welfare of the public, out of the ranks of physicians, dentists, nurses, and laymen was organized an independent group which led to the defeat of proposed vicious legislation; and as a direct result of this medical crisis there has been welded a unity of spirit, an *esprit de corps* which must carry us on to other achievements in the future as champions of public health.

THE COMPONENT COUNTY MEDICAL SOCIETIES OF THE CALIFORNIA MEDICAL ASSOCIATION

One of the privileges of the president of this Association, as well as one of his duties, is to visit

the component county societies; and in the fulfillment of this duty I was inspired by the unity and the harmony in which the members of our profession are working. A politician once said: "Only once in every thirty years does the medical profession become sufficiently aroused to become a serious political factor; but when it does, it organizes and operates most effectively." The history of the past year of the profession in this State would seem to prove that he was right. Medical self-esteem has risen and harmony has been promoted, and we have been stimulated to repay, with even greater service, the confidence expressed by the people.

IN CONCLUSION

As we grow older, most of us become conservative, and some of us become reactionary. We must not let our natural conservatism blind us to the fact that we are living in an era of social and economic change, and that, as Grover Cleveland once said, "These are not theories that confront us; they are conditions." In the reasonable consideration of such problems as are confronting us today, it is most important to remember that change is not in itself bad, and that the fact that a thing is new is not a sound reason for its condemnation.

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RESEARCH IN MEDICINE: PRACTICAL APPLICATIONS*

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WE who are practicing medicine in this enlightened age at times are prone to look upon the methods employed by our predecessors in the profession with an attitude tinged with condescension. We often fail to realize the darkness through which they traveled, and the wonders which they accomplished with the few means at their disposal. The physician of ancient times, hindered in his progress by superstition and religious intolerance, and lacking the principles of the basic sciences from which so much of our knowledge has been derived, would look with awe upon the methods of diagnosis at our command, the vast array of conditions remediable by surgical intervention, and even the therapeutic equipment contained in the ordinary emergency bag of the present-day practitioner. It is the purpose of this paper to sketch briefly the manner in which this change in scientific endeavor was brought about, and what it has meant to the civilized world.

THE PRACTICE OF MEDICINE IN ANCIENT TIMES

The practice of medicine existed as a highly developed profession in Babylonia and in ancient Egypt, but direct care of the patient was associated with magic, witchcraft, superstition, and religion. Nevertheless, the Egyptians possessed a formidable materia medica, and many of the remedies have descended to our day. They originated the science of chemistry, and knew of the antiseptic value of extreme dryness as well as of chemicals such as niter and common salt. Egyptian medicine, however, languished and gradually merged with that of Greece.

THE DAWN OF RATIONAL MEDICINE

The dawn of rational medicine began in Greece under the influence and guidance of Hippocrates. He was the first to realize that disease was a part of the processes of nature, and was not divine in origin. With no other instruments than an open mind and keen senses, he classified diseases according to symptoms, emphasized the importance of careful observation, and was ever on the lookout for sources of error, which is the very essence of scientific spirit. Hippocrates was not acquainted with experiment, but he profited by experience. His description of epilepsy, puerperal sepsis, and other diseases would need but little change if printed in the textbooks of today.

Galen continued the Hippocratic method of observation and instituted the first experiments in physiology. Some of his anatomical descriptions were very good, but much of his talent was overshadowed by a tendency to obscure the facts by theoretical dogma. So profound was the effect of his teaching that, up to the time of Vesalius, his word was taken as final in any argument.

MEDICINE DURING THE DARK AGES

After Galen's death, European medicine remained at a standstill, and much was forgotten during the Dark Ages. However, at the time of the Renaissance, medical as well as other sciences were included in the great upheaval. New enthusiasm for Hippocrates and Galen began to flourish; this was largely due to the invention of the printing press. Rapid strides were made in the sixteenth and seventeenth centuries, and anatomy and physiology began to be studied intelligently. The greatest advancement during this period may be attributed to the book on anatomy by Vesalius in which he corrected many of Galen's misconceptions. Great was the furore aroused by this work, and it was many years before its true value was recognized.

THE BEGINNING OF MODERN MEDICINE

Modern medicine may be said to have originated at the time Harvey described the circulation of the blood. Although his discovery was of extreme value in itself, it opened a new field of medicine, for it was the first time that a definite medical problem had been solved by a combination of experimentation and observation. Following the example set by Harvey, rapid strides were made in the basic sciences, such as physiology, anatomy, chemistry, and physics. About this same time the invention of the microscope aroused a mild interest in the invisible world, but it was years before minute organisms and cellular changes in the tissues were associated with disease.

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On the other hand, the curative side of medicine remained in about the same stage as in the time of Hippocrates. The art of observation had been further developed and, as a consequence, many features of various diseases were known and the general knowledge of anatomy had increased. Linnæus set the vogue of classification in medicine as well as in botany, and from this time on, diseases were classified, symptoms were correlated, and descriptions of findings at necropsy were reported. Later, the names of Graves, Bright, Hodgkins, Addison and many others were intimately associated with diseases which were supposed to have been originally described by them. Nevertheless, these men only began to understand how the body functioned, for the cause of disease and rational methods of treatment were still unknown. One exception must be made, however: in 1796, Jenner demonstrated the value of vaccination in cases of smallpox, but one hundred years elapsed before the principles underlying acquired immunity were realized.

CONTRIBUTIONS DURING THE NINETEENTH CENTURY

About the middle of the nineteenth century many of the medical problems which had hitherto persistently resisted all attempts at solution gradually began to fall into their component parts after the discoveries made by Pasteur and Koch. Pasteur, a chemist, became interested in the field of biology through his studies of the fermentation of wine. At the conclusion of his successful work on the silkworm, which proved for the first time that biological problems could be solved by experimental methods, he was carried into the realm of bacteriology by an investigation on chicken cholera. His discovery of preventive inoculation was due to the accidental finding that virulent cultures of chicken cholera virus became inactive upon standing. He then observed that when the chickens which had failed to develop the disease were reinjected with material from fresh cultures, no untoward effects could be detected. When these principles were applied successfully in the treatment of anthrax in animals and hydrophobia in human beings, the science of immunology was born. In 1878 Koch introduced a new method of obtaining a pure culture, and conclusively demonstrated the relation of bacteria to disease. As a result of these discoveries greater advances were made in the next fifty years through experimental methods than had been accomplished in 2,500 years of observation.

DAWN OF MODERN SURGERY

The dawn of modern surgery, while closely related to the work of Pasteur and Koch, was ushered in by Lister, who was the first to visualize the possibilities of antisepsis in the operating room. It has often been said that surgery had almost reached the end of its progress when it was set free by Lister and his contributions, which have been of such great benefit to mankind. However, it should never be forgotten that the field of surgery would have been forever limited had it not been for the discovery of anesthesia. Thus, the surgeons in the nineteenth century, never lacking in skill and possessing a means of alleviating pain as well as a knowledge of the work of Pasteur and Lister, revolutionized their craft to such an extent that within a comparatively few years the entire body was included within its realm.

INFLUENCE OF THE SCIENCE OF BACTERIOLOGY

Before the time of Pasteur and Koch, so far as the curative side of medicine was concerned, there was little to light the pathway for the sick or for those who attended them. However, when microörganisms began to be definitely associated with disease, the minds of men received a new impulse, and their thoughts took a new direction. Consequently, great contributions were rapidly made by a long line of bacteriologists.

Only after the germ that causes *tuberculosis* had been discovered by Koch could mankind hope to eradicate this disease which has killed millions. Prophylactic measures, as well as new methods of treatment, were soon instituted and constantly improved, with the result that the changes in the mortality statistics in this country have been more promising from year to year.

Everyone is familiar with the large ward set aside primarily for the treatment of patients with *typhoid fever* in former days. This situation has entirely changed since the discovery of the Bacillus typhosus by Eberth in 1880. When it was found that chlorin killed the organism, chlorination of the city water supply eliminated one of the greatest sources of danger. In addition, the extensive use of vaccine prepared by Wright and Haffkine, and the improvements in diagnosis described by Widal, have been instrumental in lowering the death rate of typhoid fever to 1.5 per 100,000 of our population. As a result, so few are the cases seen at the present time that a medical student may see only one or two of these patients during the four years of his college course.

At the present time it is difficult to realize that *smallpox* used to claim 600,000 lives each year in Europe, and that in 1792 all of the population of the city of Boston had the disease except those who had had it previously. We have to thank the inquisitiveness and perception of our English country doctor for the methods at our disposal for control of the disease. While it had long been known that a patient who had suffered from cowpox never developed smallpox, no one realized the significance of the observation until Jenner published the results of his experiment. He had applied a small amount of cowpox virus, obtained from the lesion on the hand of a milkmaid, under the skin of a small boy; subsequently, when the boy was inoculated with smallpox virus, he failed to develop the disease. In this enlightened age everyone knows that, owing to the widespread practice of vaccination, smallpox is rare. On the other hand, how many realize that in the United States there were 48,000 cases of this disease in 1930, when there should have been none?

PREVENTIVE INOCULATION

The value of preventive inoculation against various diseases is well illustrated by what has been accomplished in the treatment of *diphtheria.* It is difficult to conceive practicing medicine today without an effective means of curing certain diseases. The new germs discovered in the throats of diphtheric patients by Klebs and Loeffler were found to produce a poison which was fatal when inoculated into animals. However, Behring observed that, if a non-fatal dose was administered, the animals eventually developed an immunity to the poison. He next noted that the blood serum of these resistant animals contained an anti-poison that neutralized the diphtheria poison. When he had successfully proved the value of this serum among human beings suffering from diphtheria, the scourge was chained that had been claiming the lives of half the patients afflicted, constituting thousands of individuals annually. Not many years afterward, following much experimentation on animals, science discovered toxin-antitoxin and toxoid which, when injected under the skin, renders the individual immune to the disease. Nevertheless, in the light of all this knowledge, there were 65,000 cases of diphtheria in this country in 1930. Only three hundred deaths from diphtheria in the city of Chicago was considered an excellent record in 1930; however, in 1933, the number of deaths was reduced to nine through the conscientious effort on the part of the physicians of that city in employing toxin-antitoxin and toxoid. This serves to indicate what might be accomplished by the organized medical profession supported by the public's coöperation.

At present we know more than ever before about the prevention and treatment of such diseases as *scarlet fever, whooping-cough, measles,* and *infantile paralysis.* This last has baffled scientists for many years, but, owing to recent investigations, we not only have a means of combating it, but we soon should be able to prevent by vaccination the crippling effects of this disease.

INSECT-BORNE DISEASES

The devastating epidemics of *malaria,* a disease known to Hippocrates and one that contributed to the fall of the Roman Empire, continued to ravage the civilized world until Laveran discovered the parasite in the blood of suffering patients, and Manson demonstrated the mosquito-malaria relationship. While the disease is still in evidence in swamp-ridden tropical countries, the death rate in America has been reduced to two per one hundred thousand inhabitants.

Following Manson's vision of insect-borne diseases, Reed, Lazear, Agramonte, and Carrol were appointed as a commission to investigate *yellow fever,* which was the disease that drove the populace out of Philadelphia soon after the Revolutionary War. After a prodigious and courageous search, during which Lazear lost his life while permitting himself to be used as an experimental subject, the etiologic agent of yellow fever was found to be carried by the mosquito (colopus). As a result of the commission's report, the United States Public Health Bureau, through the medium of rigid hygienic measures, has completely rid the country of this dangerous menace.

The knowledge of *protozoan and bacterial diseases* was put to a valuable test in 1904. Pestilence had played a large part in defeating past attempts to build the Panama Canal, and so the United States appointed a Health Commission to study the situation before it undertook the project. Malaria and yellow fever were banished, and dysentery was kept under control. In less than two years the mortality among the workers was materially reduced, being one-third of what it formerly had been. This is an excellent example of statesmanship directed by medical science.

Time does not permit a description of the methods by which typhus fever, the plague, and many other devastating diseases were conquered; nevertheless, sufficient has been said to indicate the extent of our indebtedness to the ones who carry out these researches.

THREE FACTORS IN THE DEVELOPMENT OF RESEARCH

Previous history having taught the value of experimentation, tremendous progress was made in our knowledge of the functions of organs and associated diseases not caused by bacteria. Research must advance through three essential steps before success is certain. After discovering the presence of a disease, its nature and cause must be determined. Usually the second step is to reproduce the disease in animals in order to learn how to prevent and treat it. Then, after the preliminary experiments in animals have been completed, the results are applied to man. In most instances success comes only after years of ceaseless, painstaking effort on the part of many men. Research cannot be hurried, for each man, before offering a contribution, must grope through darkened byways until the ultimate goal is reached and the average life span is increased one or two years more.

COMMENTS ON DISCOVERIES HAVING TO DO WITH CERTAIN DISEASES

Claude Bernard was the founder of the artificial production of disease by means of chemical and physical manipulation. It was he who coined the term "internal secretion," in describing his remarkable discovery of the *glycogenic function of the liver,* which has been of inestimable importance. Up to his time, gastric digestion constituted the sum total of the physiology of digestion. He cleared up the entire subject by showing that the gastric juice merely prepared the food for the digestive ferments produced by the pancreas, and he thereby laid the foundation for our studies on digestion and nutrition. In addition, the success which we have attained in the treatment of hypertension, Raynaud's disease, scleroderma, and other allied conditions, may be directly attributed to his discovery of the vasomotor mechanism.

The records of a Greek physician, Alexander Trallianus, show that *gall-stones* were recognized as an entity in the sixth century. In ancient times

bile and gall-stones were thought to cause remarkable cures when used as therapeutic agents. For instance, Rhases, an Arabian physician, about 900 A. D., wrote that the stones from the gall of an ox were ground up and drawn into the nostrils to promote sharpness of vision. If stones were not available, the bile of a black ox might be substituted. It was thought that if an animal had gall-stones it was suitable for eating; but if the calculi had sharp edges, the animal was unfit for food. In the thirteenth century it was recorded that "some animals have no gall-bladder at all; some have the gall-bladder in the belly, and some have it in their ears." In ancient Babylon the idea arose that future events could be predicted by the condition of the gall-bladder of a sacrificial animal: if the right side of the gall-bladder appeared swollen, it pointed to an increase in the strength of the King's army. Swelling of the left side was considered an indication that the enemy was likely to be successful. In our day, mention of the biliary and digestive tracts recalls the names of Mann, Bollman, and their associates, for they have made some of the outstanding contributions to the knowledge of the physiology and pathology of the gall-bladder and liver. Mann was among the first to produce chronic peptic ulcer experimentally. This led to a more thorough understanding of the processes involved in the etiology and treatment of that condition. Their more recent studies on blood flow indicate that we may look forward confidently to revealing information on that subject.

All of us have friends who are enjoying life but who, except for the discovery of insulin, would be dead or existing only in a starved and miserable state. The cause of *diabetes* was established for the first time when, in 1889, two scientists removed the pancreas from a dog and produced this disease. However, it was not until a little more than ten years ago that Banting and his co-workers succeeded in isolating the hormone produced by the islands of Langerhans, which hormone is lacking in diabetic patients. Children having this disease formerly died in one or two years, but they now grow into healthy men and women. The life of adult diabetics has also been definitely prolonged. Statistics reveal that there are at least two million people in the United States alone who have benefited by this discovery.

That dreaded disease, *pernicious anemia,* has also been conquered in the past few years. The discovery of the value of liver therapy was the direct outcome of years of work by Whipple, Minot, Murphy and Robbins, who were endeavoring to learn the value of different diets in the treatment of experimental anemia in dogs and rats. As a result of their endeavors, thousands of individuals who formerly were doomed to slow but sure death can be maintained in excellent health at little inconvenience to themselves.

The advances in the mode of recognition and treatment of *diseases of the thyroid gland* during the past twenty years constitute a record of achievement as brilliant as any our age can boast. Parry, in 1825, and Graves, in 1835, gave accurate descriptions of hyperthyroidism, but it was not until 1886 that Möbius definitely ascribed the condition to an abnormality of the thyroid gland. The next step in advance was made by Müller, in 1893, when he found that the output of nitrogen in exophthalmic goiter considerably exceeded the intake. This was followed in 1895 by the work of Magnus-Levy, the outcome of which was a study of the basal metabolic rates of these individuals. Kendall finally succeeded in isolating thyroxin in crystalline form in 1914. Subsequent research by Kendall, Plummer, and Boothby resulted in the revelation that "thyroxin is a catalytic agent, hastening the rate of formation of a quantum of potential energy available for transformation on excitation of the cells." As a result of the combined efforts of these men, another drug was added to the therapeutic agents at the physician's disposal in the treatment of disease; for prior to this time the apathetic appearance and imbecility associated with myxedema were irremediable. Then, in 1922, Plummer introduced the use of iodin in the preoperative preparation of patients suffering from exophthalmic goiter. It may be said that this treatment with iodin has placed the surgery of exophthalmic goiter on a sound basis by reducing the severity of all of the manifestations of the disease, and by eliminating the long-feared and dangerous surgical complications. Thus the obstacles to surgery in this field finally yielded before the persistent efforts of a comparatively few men.

The *suprarenal glands,* regarded by the ancients as possessing miraculous powers and described by Addison from the clinical standpoint, are now known to produce at least two hormones. The value of one of these, epinephrin, has been demonstrated; but it was only recently that Kendall was able to isolate in crystalline form the other, which is essential to life. From his preliminary work with human beings as well as with dogs, it appears that yet another fatal disease has been mastered by providing substitution therapy.

Little was known of the minute parathyroid bodies until MacCallum demonstrated their relationship to calcium metabolism in 1908. Another twenty years went by before Hanson, a general practitioner interested in chemistry and working in his laboratory in spare moments, actually isolated the active hormone. Collip later substantiated Hanson's work, and proved the value of the preparation in the treatment of those unfortunate individuals suffering from parathyroid tetany.

In addition to the work already considered, that on the pituitary body, thymus, and sex organs, indicates that we may confidently look for even more revealing and valuable discoveries in these fields in the near future.

VALUE OF THE KNOWLEDGE ACQUIRED FROM THE EXPERIMENTS OF CHEMISTS AND CHEMICAL PHYSICISTS

As men of science, it is not difficult for us to appreciate the revolutionary changes in the civilized world which have resulted from the experiments conducted by the chemist and chemical

physicist. Without their aid the age of electricity would not have been possible, nor would we have the diagnostic and therapeutic uses of roentgen-rays or radium. The organic chemist has not only shed light on the complex processes occurring in the body, but has also produced many therapeutic agents. It is difficult for us to conceive of practicing without cocain, novocain, salicylic acid, acetanilid, eserin, pituitrin, salvarsan, and innumerable other drugs, all of which are of comparatively recent origin. A new era in the diagnosis and treatment of deficiency diseases was ushered in through the discovery, mainly by biochemists, of the vitamins which are so essential to life.

CIVILIZATION'S OBLIGATIONS TO RESEARCH WORKERS

This presentation has necessarily been brief, and many important findings have been omitted; likewise, much of the routine work has been overshadowed by the spectacular. However, we also wish to pay tribute to those individuals whose contributions have been of inestimable value to the medical profession. Some of the greatest contributions have been made by those who work single-handed while engaged in an active practice, and too often at great physical expense. In the present rather revolutionary period, many changes in our methods of practice have been suggested. Too often in time of turmoil the distractions outweigh the incentive, and it is impossible to progress with maximal efficiency. Research has been defined as "a method of keeping everyone reasonably dissatisfied with what he has." There never was a greater need for original investigation, or a better opportunity to salvage time for it than the present.

PURE SCIENCE INVESTIGATION AND CLINICAL OBSERVATION ARE BOTH IMPORTANT

Much has been written concerning the methods that should be employed in conducting original investigation, but it should be pointed out that, although there are some fields of study best left in the hands of the so-called pure scientists, research is not confined to the laboratory worker alone. Accurate observation of signs and symptoms, and their correlation with disease, will always be essential. In addition, there are certain phases of research which cannot be conducted by the laboratory investigator. The study of the earliest changes in disturbed function, which later develop into a definite clinical entity, lies solely within the realm of the family physician. Moreover, the science of prognosis and the evaluation of therapeutic remedies when applied to man necessitate an acuteness of observation during the progress of the disease which the scientists alone cannot appreciate. There can be no doubt that, although closely related, the fields to be conquered by laboratory methods and curative medicine are different. In order to progress with maximal efficiency, not only must observatory and experimental methods be coördinated, but there must also be an intimate contact between the investigators and the disease as it exists in man.

IN CONCLUSION

In conclusion, it seems to be in order to determine the results of all this knowledge which we have struggled so long and so diligently to obtain. One would be making a conservative estimate in stating that there are fifty million people in this country today whose lives have been saved or prolonged through medical science. While there are those who might question such an assertion, the figures are easily arrived at. One hundred years ago the average span of life was thirty-five years; today it is sixty. Since there are 126,000,000 people living in these United States, it is a simple problem to calculate the number of individuals whose existence at the present time is dependent upon the measures which have been instituted to prolong life. Moreover, seven years have been added to the average life span in the last twenty-three years, for in 1911 the average length of life was only fifty-three years. This also means that there are 13,000,000 people alive today who would have been dead but for the progress made in medical science. At the present rate of increase in knowledge, man can look forward to an average of sixty-five years of life by 1944. The battle in which we are active participants will never cease, for the diverse ramifications of our science are bound to hold our interest. However, it is the judicious employment of these days that will continue to advance the front of our knowledge during this period, and speed it on its way to even greater heights.

The Mayo Foundation.

THE DIFFERENTIAL DIAGNOSIS OF INTRACRANIAL DAMAGE*

By E. J. Morrissey, M. D.
San Francisco

Discussion *by Howard C. Naffziger, M. D., San Francisco; Carl W. Rand, M. D., Los Angeles; Howard W. Fleming, San Francisco.*

THE symptoms and signs of cerebral injury may result not only from intracerebral lesions, namely, concussion, contusion, laceration and intracerebral hemorrhage, but also from cerebral compression due either to depressed fractures, extradural or subdural hemorrhages.

DIFFERENTIAL DIAGNOSIS

The differentiation between these conditions is the essential point in determining the method of treatment.

Concussion.—Unfortunately in the past the term concussion has been used in a very elastic manner to include severe cerebral contusion and even laceration.

At present it is customary to designate as concussion head injuries in which no definite pathological changes are apparent.

* From the surgical service of Stanford University, San Francisco County Hospital, Department of Public Health.

Read before the General Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

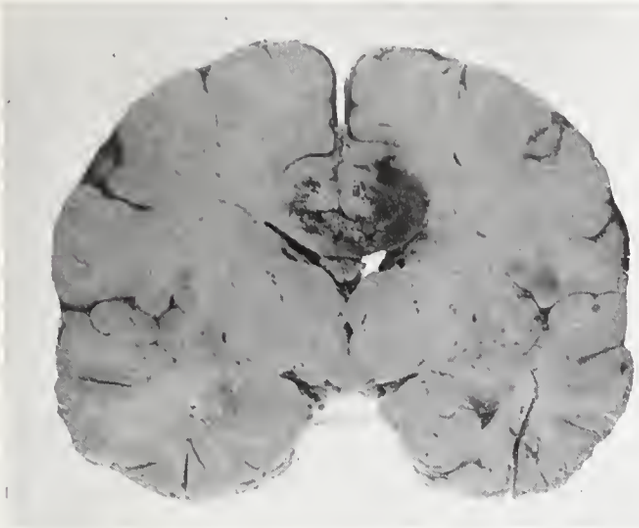


Fig. 1.

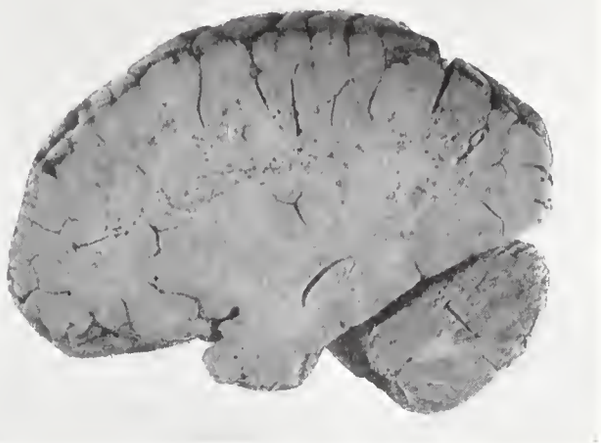


Fig. 2.

The term, however, will probably be discarded. I am certain that as our methods of investigation advance we will be able to demonstrate pathological changes in those specimens that are now considered as normal.

As a result of the studies of Cajal and others, this has already in part been accomplished.

Contusion.—Contusions of the brain may vary from a few petechial hemorrhages to extensive bruising of the cortex and underlying tissues.

The petechial hemorrhages have a tendency to group themselves about localized areas. (See Fig. 1.) This grouping is one of the distinguishing points between petechial hemorrhages resulting from trauma and those following emboli, infection, etc. (See Fig. 2.)

Laceration.—Laceration of the brain is a definite tearing of the tissues, and is naturally associated with hemorrhages into the surrounding brain tissue, and usually into the subarachnoid and subdural spaces.

Lacerations may be found at any point, but they are especially common over the bases of the frontal and temporal lobes. They may be directly under the point of injury, but are usually *contrecoup.*

Hemorrhage.—Extracerebral hemorrhage may be either extradural, subdural (acute or chronic), or subarachnoid.

Extradural Hemorrhage.—Extradural hemorrhage practically always results from a rupture of the main trunk or one of the branches of the middle meningeal artery.

In rare instances it occurs from either a tearing of one of the large venous sinuses or a separation of the dura from the skull at the time of the accident, with bleeding from the bone.

The bleeding from the torn vessel or vessels strips the dura from the skull, and as the hemorrhage enlarges symptoms of compression ensue.

Extradural hemorrhages, as a rule, are disc-shaped, thin at the margins and thick in the center. They may be of any size, varying in weight from a few to over two hundred grams.

Moody, in one hundred autopsies, found the average weight of the clot in fatal cases to be one hundred and ten grams.

The majority of extradural hemorrhages occur in patients between the ages of twenty and fifty. They are rare in childhood and elderly people. In Vance's series of sixty-one cases only three occurred before the age of twenty.

As a general rule the symptoms resulting from these hemorrhages make their appearance within the first twenty-four hours. The time interval may vary, however, from a few hours to several days, depending entirely on the rapidity with which the dura is stripped from the bone.

Subdural Hemorrhages.—When the force of the blow is sufficient to cause either severe cerebral contusion or laceration of the cerebral veins with tearing of the arachnoid, we have bleeding into the subdural space.

These subdural hemorrhages may be either unilateral or bilateral, and likewise may vary in size from a small localized clot to a large hemorrhage sufficient to cause marked cerebral compression.

Vance, in 512 autopsies, felt that death was due to cerebral compression by a large collection of dural blood in 132 cases. The average weight of the clot was 61.1 grams.

Chronic Subdural Hematomas.—Chronic subdural hematomas differ from the acute subdural hemorrhages spoken of above and lie, as Virchow was the first to show, in the subdural space. They are surrounded by a definite capsule and are often bilateral.

Trotter and others believe that the bleeding is due to injury of the veins passing from the brain to the tributaries of the superior longitudinal sinus.

In the great majority of cases they occur some time after what was apparently a very minor head trauma. This period, between the injury and the development of symptoms, may vary from a few weeks to several months or even years. Often the initial injury is so slight and the elapsed time before the start of symptoms so long that it is entirely forgotten.

TABLE 1.—*Differential Diagnostic Points*

	Contusion Laceration	Extradural Hemorrhage	Chronic Subdural Hematoma
Unconsciousness	Immediate	Stupor coming on after a latent period. If initial injury severe latent period may be absent.	Latent period varies from few weeks to many months.
Temperature	Fall at first due to shock. Rise following depending on severity. When above 104 degrees recovery rare.	No rise.	No rise.
Pulse and Respirations	Rapid in shock. Slow in medullary involvement. Rapid in medullary failure.	Slow.	Slow.
Blood Pressure or Pulse Pressure	Increase with medullary involvement.	Increased.	No increase.
Spinal Fluid	Contains blood—amount depends on severity. Pressure varies.	No blood unless contusion or laceration present. Pressure increased.	Either slightly blood tinged, xanthochromic or clear.
Neurological Findings			
(a) Weakness or paralysis	Immediate.	Late and progressive.	Gradual and progressive. Occasionally on same side as hemorrhage.
(b) Pupils	Very dilated on side of lesion. Dilated and fixed prognosis poor.	Dilated as a rule on side of hemorrhage.	Often dilated on side of hemorrhage.
(c) Ophthalmoscopic	Negative first 24 hours at least.	Negative.	Bilateral choked discs usually present; greater on side of hemorrhage.
X-ray Findings	Fracture may or may not be present.	Fracture line crossing middle meningeal groove usually present.	Usually no fracture. Pineal shifted.

Following the latent period we have the history and findings of gradually increasing intracranial pressure, namely, headache, nausea and vomiting, visual disturbances, choked discs, etc. In view of these facts, it is extremely important in any case of gradually increasing intracranial pressure to go carefully into the past history.

Subarachnoid Hemorrhages.—Bleeding into the subarachnoid spaces occurs in practically all cerebral contusions of any severity.

It varies from merely a slight pinkish discoloration of the cerebro-spinal fluid to the point where it is practically pure blood.

Essick, Bagley, Fay and others believe that this condition accounts for adhesions and blockage of the circulation of the cerebro-spinal fluid, and many of the post-traumatic cerebral symptoms.

Subdural Collections of Cerebro-Spinal Fluid.—A discussion of the differential diagnosis of intracranial lesions would not be complete without mention of the localized subdural collection of cerebro-spinal fluid first spoken of by Naffziger. These cases present symptoms and findings very similar to extradural hemorrhages.

SPECIAL SYMPTOMS

Unconsciousness. — The duration of the period of unconsciousness immediately following a head injury is in direct proportion to the severity of the cerebral damage.

The general rule may be laid down that the longer the period of unconsciousness, the more severe the cerebral contusion or laceration and the more guarded must be the prognosis.

Occasionally we see deaths resulting in patients who were not unconscious following the accident. In these cases it is practically always due to some complication, such as subdural or extradural hemorrhage, meningitis, etc. There is, of course, the occasional case of continued bleeding into the cerebral tissues following a laceration.

Stupor, coming on gradually after a period of consciousness, is practically always the result of an extradural hemorrhage. The period of consciousness is spoken of as the latent period and may vary from a few minutes to hours or even days.

It must always be borne in mind, however, that the initial period of unconsciousness due to the contusion may be of sufficient length that it overlaps the unconsciousness resulting from the hemorrhage, and that, therefore, there will be no latent period.

Temperature.—The temperature rise within the first twenty-four hours is likewise a fair indication of the amount of cerebral contusion or laceration. In the average case, immediately following the injury, there is a fall in temperature, the result of shock followed by a rise above normal.

In those cases in which recovery takes place the average varies between 101 and 103 degrees. As a rule recovery seldom occurs when, as a direct result of the cerebral trauma, the rise is above 104 degrees.

Pulse and Respirations.—The point has always been emphasized that slowing of the pulse and respirations, especially when associated with rise



Fig. 3.



Fig. 4.

in blood pressure or a widening pulse pressure, is indicative of increased intracranial pressure.

This is not the entire truth. What this syndrome indicates is medullary involvement.

Before this was realized, one occasionally was surprised, at operation or postmortem examination, to find the brain shrunken and fallen away from the dura in those cases that had marked slowing of pulse and respirations. The measurement of the spinal fluid pressure is a good indication as to whether or not these medullary symptoms are due to increased intracranial pressure.

It is extremely important to bear the above point in mind when the question of dehydration is considered in the treatment of head injuries.

Slowing of pulse and respirations, with a rise in blood pressure or widening pulse pressure, when due to increased intracranial pressure is a result of either brain edema or hemorrhage.

If it occurs within the first twenty-four hours it is most likely due to an extradural hemorrhage. In Vance's series of postmortem examinations, on 106 cases of extradural hemorrhage, death occurred in over 50 per cent within the first twenty-four hours.

When the symptoms make their appearance after the first twenty-four hours they are more likely to be the result of cerebral edema, secondary to contusion or laceration.

On the other hand, when we have these findings occurring weeks or months after an injury, we may with certainty make a diagnosis of a subdural hematoma.

NEUROLOGICAL EXAMINATION

A careful neurological examination made immediately following the accident is the best method of distinguishing between lesions due to contusion or laceration and those resulting from hemorrhage.

If immediately following cerebral trauma there is a weakness or paralysis with definite reflex changes, then it is no doubt the result of contusion or laceration.

On the other hand if the first examination is negative and subsequent findings reveal a gradually developing paresis, especially starting about the face, then it is most probable that we are dealing with an extra- or intradural hemorrhage. Occasionally, however, this picture is presented by increasing edema about a laceration or an enlarging subcortical hemorrhage.

The pupillary findings are extremely important. They are valuable both from a prognostic and diagnostic point.

Patients with bilaterally dilated and fixed pupils very seldom recover. In Blakslee's series of 610 cases of fracture of the skull with bilateral dilated and fixed pupils, 95.5 per cent died. The existence of previously fixed pupils must, of course, be kept in mind.

Unilateral dilatation with fixation of the pupil occurs as a rule on the same side as the cerebral involvement and may be due to either cerebral contusion or extradural hemorrhage.

A gradually developing unilateral dilatation of the pupil is more likely the result of an extradural hemorrhage. Occasionally it is the only positive localizing sign. This point has been emphasized especially by Holman and Scott, Lyerly and others.

Evidence of choking of the optic discs is extremely rare in the first forty-eight hours, even though there be fairly marked increased intracranial pressure. Ophthalmoscopic studies should be made as soon as possible, because then we are in a position to note the early signs suggesting increased intracranial pressure such as engorgement and tortuosity of the veins, blurring of nasal margins and hyperemia of the discs. A choking of the discs, on the other hand, is a common finding in chronic subdural hematoma.

A mydriatic should not be used within the first few days because one is then unable to follow pupillary changes which are extremely important.

SPINAL PUNCTURE

Measurement of the pressure and the examination of the spinal fluid is extremely important. Blood in the spinal fluid is found in practically every cerebral contusion of any severity and in all lacerations. As a rule the more severe the cerebral injury the higher the percentage of blood in the spinal fluid. Likewise the more guarded must be the prognosis.

If clear spinal fluid is obtained in a patient presenting the signs and symptoms of increased intracranial pressure then we are more than likely dealing with an extradural hemorrhage.

It does not follow, however, that the presence of blood in the spinal fluid rules out an extradural hemorrhage. Very often cerebral contusion is also present.

The diagnosis of meningitis is likewise verified by examination of the spinal fluid. It must be remembered, on the other hand, that blood in the spinal fluid, especially in the region of the posterior fossa, will cause the usual signs suggesting meningitis, namely, stiffness of the neck and bilateral Kernigs.

ROENTGEN-RAY FINDINGS

Everyone recognizes that there is no direct relationship between the degree of brain injury and the presence or absence of a fracture, and that patients who are in extremely poor condition or in shock should not be subject to roentgen studies. However, we often obtain valuable information which enables us to make a diagnosis.

Extradural hemorrhages occur in the absence of fracture, yet they are much more likely to be present with a fracture crossing the grooves of the middle meningeal artery or its branches. Occasionally, in an unconscious patient, the presence of a fracture crossing one of these grooves is the most important deciding and localizing factor.

What has been a great aid to us in making a diagnosis of a hemorrhage either extradural or subdural is the shifting of the pineal body. It has been useful especially in those cases in which the hemorrhage is on the same side as the symptoms. Fig. 3 illustrates the shifting of the pineal in a large subdural hemorrhage and Fig. 4 the return to normal position after removal of the hemorrhage.

Occasionally we find, associated with cerebral contusion or laceration, a hemorrhage either extra or intradural and of sufficient size to in itself produce symptoms of cerebral compression. These cases are extremely difficult to diagnose, because the symptoms and findings of one tend to mask those of the other.

Le Count and Apfelbach, in reporting a series of extradural hemorrhages, made the statement that only 52.26 per cent were of sufficient size to cause death; and as stated, Vance, in 512 autopsies, felt that death was possibly due to cerebral compression by a collection of subdural blood in 132 cases.

When the above is encountered the question always arises as to whether or not a certain percentage of those cases would have recovered from the cerebral damage were the extra burden of the hemorrhage removed.

A diagnosis, if it is to be made, demands careful observation with frequent neurological examination for evidence of change. One has no right to assume, because he finds bloody spinal fluid and other evidence of cerebral contusion or laceration, that all the ensuing symptoms are a result of this lesion.

If there is any question, trephine openings should be made. By our present methods there is no shock associated with this procedure, and if a hemorrhage is found and evacuated, the patient has a far better chance to recover.

I would rather operate on a patient and not encounter a hemorrhage than to find at postmortem that a hemorrhage had been overlooked.

909 Hyde Street.

DISCUSSION

Howard C. Naffziger, M.D. (University of California Medical School, San Francisco).—The statistical points quoted by Doctor Morrissey are helpful in forming our clinical judgment and in prognosis. The management of craniocerebral injuries does not require particularly refined methods of neurological examination, nor does the state of the patient usually permit them.

Proper interpretation of the physiological disturbances of consciousness, of respiration, heart rate, and blood pressure are of paramount importance. By these and the gross neurological manifestations, our treatment is guided.

The physiological responses to acute cerebral compression have been well established in laboratory experimentation. In our patients, however, these well-known alterations may be lacking, and we may find bizarre responses to brain compression. For example, an increasingly rapid pulse may be associated with a rising intracranial pressure instead of the expected slow pulse. In such instances we are dealing with the reactions of a traumatized and contused brain—one which behaves differently from the untraumatized but otherwise normal brain, which is being subjected to gradual compression in the experimental animal.

Doctor Morrissey's presentation makes clear, I think, that only a small proportion of patients with craniocerebral injuries are benefited by operation.

❦

Carl W. Rand, M. D. (523 West Sixth Street, Los Angeles).—Doctor Morrissey has given a very excellent differential diagnosis of the various types of intracranial hemorrhages following head injury. His reference to the pineal shift in certain cases of chronic subdural hematoma and of large subdural hemorrhages is timely. It is felt that x-ray plates should be studied more carefully for the possibility of pineal shift in suspected cases of intracranial hemorrhage.

❦

Howard W. Fleming, M. D. (384 Post Street, San Francisco).—Doctor Morrissey's paper on "The Differential Diagnosis of Intracranial Damage" is most timely.

No diagnostic problem is more open to controversy. Recently, well-known authorities have expressed their opinions as to the diagnosis and treatment of head injuries in a most dogmatic manner. Diametrically opposed methods have been advocated so forcefully that the medical profession is at a loss to know how to treat their cases. Only too frequently this indecision leads to procrastination, and opportunities for effective therapy are overlooked.

Judicial use of all recognized methods will result in a far greater percentage of correct diagnosis. There

is no substitute for a careful history followed by frequently repeated examination. Spinal puncture and x-rays often are helpful. Each case is an individual problem, but careful evaluation of all information to be obtained usually suggests the nature and extent of the intracranial pathology.

The methods and conclusion, as given by Doctor Morrissey, are those generally accepted by the great majority of neurological surgeons.

Doctor Morrissey (Closing).—In conclusion, I wish to thank the various men who have discussed this paper, and emphasize the fact that each case is individual in itself, and that one should not adhere too closely to any general rule.

URETHRAL STRICTURES—A RÉSUMÉ OF TREATMENT*

By Wilbur B. Parker, M. D.
and
Chester H. MacKay, M. D.
Los Angeles

Discussion *by Elmer Hess, M. D., Erie, Pennsylvania; Henry A. L. Kreutzmann, M. D., San Francisco; Albert M. Meads, M. D., Oakland.*

THE great amount of current literature on the diagnosis of urethral strictures leads us to believe that the procedures of our preceptors were, and are today, just as accurate, and in many instances more accurate than the teachings of more recent authors. The older methods comprehended at the start an accurate clinical history, palpation, and a soft rubber catheter.

PROCEDURE WITH OBSTRUCTIONS

When obstructions are met by these simple methods, the following procedures must be resorted to:

Calibration of the urethra by use of button-sounds and button-bougies. Further, in attempting to calibrate the urethra, a size number 6 or larger should be used first. If unable to pass any of these sizes, smaller types should be attempted, down to a filiform, to be used if necessary. By this method the size, number and location of strictures can be determined.

Gentle instrumentation should be the watchword for all urologists, in diagnostic or treatment procedures. The less traumatism, the less the possibility of occurrence of complications. This rule should apply to all classes of strictures, both in male and female patients, and irrespective of their locations.

Urethrograms, whatever the opaque medium used, have been made much of in medical literature, to assist in the diagnosis and location of urethral strictures, regardless of fallacious interpretations. We must admit that a great many of the newer researches have had a scientific playground. Urethral strictures are as plentiful in number at the present time, as they have been in the past, and will continue to be so long as the human race may exist.

DEVELOPMENT OF URETHRAL STRICTURES

Time elements in the development of urethral strictures may be classified as: (1) Congenital, designated by the term that now exists and a type that does not contract; (2) Traumatic; (3) Inflammatory.

Urologists should hope to see the day when no adolescent or adult, male or female patient with a congenital stricture, will apply for treatment for a urethritis, specific or nonspecific. Without doubt they are the most unfortunate class of victims, including urethral chancre, that we have to treat today.

Traumatic strictures depend upon the amount of damage done to the urethra at the time of accident. In comparison with strictures of inflammatory origin, time of formation is much shorter. Inflammatory strictures contract slowly, depending upon the severity of the urethral infection and whether there have been any complications of the urethritis. It has been said that about one-third of inflammatory strictures occur within one year after infection, while two-thirds or more occur within two to four years.

The most frequent sites of congenital strictures are at the external meatus. Inflammatory strictures occur mostly in the phallic, bulbous and membraneous urethras, rarely in the posterior urethra. Spasmodic strictures have been denied as to whether they ever occur in the phallic and membraneous urethras. Stricture plus spasm lead to acute retention, an entity which we cannot deny. Traumatic strictures occur any place along the site of trauma, and this rule holds true in female strictures, despite the anatomical differences between the two sexes.

TREATMENT

Surgical and non-surgical treatment in private and institutional practice is usually somewhat different.

Patients in private practice are instructed to report as often as needed, in order to carry them from a filiform size to a No. 22 or No. 24 French-size dilator. Progress is often slow, and very often in the contracting types a period of six months or over is required to accomplish a successful result. Patients with filiform types of strictures are advised to report daily, until such times that it is possible to use other than filiforms. Following the filiform treatments for gradual slow dilatation, small bougies are used. In our experience, this method has caused less disturbance to the voiding ability of the patient.

Institutional patients are generally those that have been badly traumatized, and are suffering from acute retention. Such patients should be given indicated sedatation, for they rarely tolerate satisfactorily a local anesthesia, owing principally to spasm or complete occlusion at points of obstruction. For such patients, attempts are made to pass some type of catheter, preferably a Coude or natural curve type. Hospitalization usually follows, pending the reaction of the patient to relief and dilatation. If response to treatment is favorable—meaning reasonable ability to void—

*Read before the Urology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

the patients are instructed to report regularly to the out-patient department for further relief and dilatation, and advice as to the safest course to follow.

The operative procedure in any particular case is selected from one of the various types of operation such as the emergency indicates: suprapubic cystotomy, external urethrotomy, internal urethrotomy and possibly total resection of the strictured portion of the urethra.

Rarely does a urologist in private practice see a urinary extravasation, unless it follows trauma to the urethra or bladder. This type of injury requires immediate surgical intervention, with cystotomy and free drainage of the tissues involved.

As regards the divulsion and evulsion of strictures by forcible means, we are personally opposed to such measures. The so-called temporary relief, and the immediate misery to the patient gives one guarantee only—"When you have to seek future relief, you will be in a worse condition than when we last saw you." Fortunately, at the present time, such treatments are rarely resorted to.

Quite frequently cystotomy alone will reduce the inflammation at the site of the stricture, to allow dilatation to be attempted by the methods most suited to the particular case.

In all our experiences, including those of Dr. Granville MacGowan, who was our preceptor for the longest time, we can truthfully say that there are successful and humane methods of treatments for urethral strictures.

The laboratory, which can furnish blood chemistry reports in four to six hours, has been an invaluable aid in effecting decision as to risks and the best methods of relief.

In our experience, urinary extravasation caused by strictures of the urethra have been the most difficult to deal with. Out of twenty-five cases in the General Hospital, we lost four patients, even though one was operated three times within one year for the same reason. After the third operation, with a well-dilated urethra, he lost a testicle due to eversion. Our first fatal case in private practice was due to septicemia. The mortality rate in patients, including all classes of strictures, with treatment ranging from filiform size to actual resection, in some two hundred cases is not over 8 per cent.

The care of the various types of urethral strictures require much equipment. This fact is well appreciated by urologists. In one sense, it is regrettable that not infrequently urologists who do keep available all the necessary equipment do not get the first opportunity toward the relief of patients. Despite this fact, on many occasions urologists have been able to render relief under circumstances that were most unfavorable.

The treatment of strictures of the urethra have been successful except in three types: first, those caused by extensive trauma, as cases with multiple fractures of the pelvis and loss of urethral continuity; second, the non-coöperative patient; third, those who would not, or did not, report at regular intervals for a check on their calibration.

Except in a few instances of early filiform strictures, and an occasional resection type, we believe, there is no permanent cure for strictures. The saying, "Once a stricture always a stricture," still holds true, except as mentioned above. No patient can be classed as successfully cured as long as he lives, unless he or she reports regularly for examination and appropriate treatment.

527 West Seventh Street.

DISCUSSION

Elmer Hess, M. D. (8 East Twelfth Street, Erie, Pennsylvania).—This is a most timely paper. I know of no condition that is so poorly treated as strictures of the urethra, and the essayists have rightfully emphasized the one and only important thing, in my opinion, in the treatment of this condition, namely, gentle instrumentation.

How often the urologist sees patients with ruptured urethras, false passages, and extravasation of urine, due to the effort of some physician to relieve the terrifically overdistended bladder of an acute retention; and what we say here about strictures of the urethra applies equally in hypertrophies of the prostate.

It seems to me that, for the most part, practitioners of medicine who see these stricture cases first should be willing to refer such patients to a competent urologist for, at least, preliminary treatment. I would venture to say that, if this were done, the subsequent treatment could be very well carried out by the general physician, and that the accidents of that preliminary instrumentation would be reduced 95 per cent.

The authors regard devulsion and evulsion of strictures by forcible means as contrary to good practice. I believe that any competent urologist feels exactly as they do, and I was delighted to hear the remark that "quite frequently cystotomy alone will reduce the inflammation at the site of the stricture, to allow dilatation to be attempted by the methods most suited to the particular case." I would like to add to that statement that the period of time desirable to wait after the cystotomy and before attempting dilatation, is from seven to twenty-one days, depending entirely upon the condition of the patient.

It is a delight to see that the teachings of that grand old man, Granville MacGowan, have been so thoroughly drilled into those men who were associated with him that they take what I call the modern attitude in the treatment of this clinical entity, so very common and very difficult to treat.

"Once a stricture always a stricture," is a slogan that should be impressed upon the mind of every man who is called upon to treat this condition. Every patient, whether male or female, who has once had a stricture of the urethra should report to a competent urologist at least once a year, and if necessary oftener, to keep the caliber of the urethra sufficiently open so that there is no back-pressure when the urine is voided, and so that no inflammatory reaction may take place to further lessen the caliber of the channel.

Eternal vigilance on behalf of the victim, and eternal intelligence upon the part of the physician are necessary if these people are not later on to have genito-urinary pathology that may be a menace to both health and life.



Henry A. L. Kreutzmann, M. D. (2000 Van Ness Avenue, San Francisco).—The authors are to be commended for the sane and conservative viewpoint they have taken in the diagnosis and treatment of urethral strictures. Gentleness in manipulation, as they have emphasized, is of paramount importance. The brutal evulsion by large sounds is to be condemned as an unsound surgical procedure, causing more scar tissue and at times false passages. I am entirely in accord with their statement that the injection of an opaque medium into a badly strictured urethra is of little diagnostic value. Moreover, the grave complications which may result, even when only moderate pressure is used, should guard us against the routine use of this method for diagnostic purposes. We should always bear in mind the possibility of the solution penetrating

the urethral wall and entering the blood stream. This possibility is in direct proportion to the amount of pressure used.

Shortly before this meeting, I saw sections from a patient who had died about half an hour after olive oil had been injected into the urethra as a lubricant. The pressure had ruptured the weakened mucous membrane and, in consequence, the oil had been given intravenously. There was not a single organ in the body that did not contain globules of oil.

At present most traumatic strictures are the result of automobile accidents. Here we find that the descending ramus, acting like a guillotine, causes partial or complete severance of the posterior urethra. This not only results in the formation of a severe stricture, but may leave the patient impotent. I should like to hear what treatment has been most successful in the authors' hands in these cases. Immediate suprapubic cystotomy with the retrograde passage of a urethral catheter has given me the best results.

The authors have made no distinction of strictures occurring in the female and in the male. In the former excellent results are obtained and permanent cures are the rule; whereas in men their dictum of "once a stricture always a stricture" is, unfortunately, the conclusion of all who do urological work.

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Albert M. Meads, M. D. (251 Moss Avenue, Oakland).—Any pathological condition that gives rise to an 8 per cent mortality deserves attention. Therefore, the authors' paper can stand careful reading by all physicians, particularly the general practitioner who sees the larger percentage of urethral strictures first. I am glad that they have emphasized that there is no short-cut method of curing this distressing condition, but that the time-honored procedure of slow dilatation over a long period of time, with a lifetime follow-up, is the only satisfactory program for the patient who wishes to avoid crippling and fatal complications.

It has been our experience that most patients suffering from strictures fail to heed the early symptoms, as a diminishing of the urinary stream, and only seek help when compelled to by such complications as acute retention, cystitis, peri-urethral abscess, extravasation of urine, etc. Furthermore, when these conditions have been treated, and the patient is well on the way to a cure, almost invariably he takes matters into his own hands and disappears, reporting in a year or two in a worse condition than before.

The patient with acquired stricture is, as a rule, a coward when it comes to standing pain. Sometimes, I will admit, because of bad treatment, but usually just naturally so. I have seldom seen one who will not begin to "carry on" as soon as he sees a sound, and who does not quit treatment long before he is advised to, preferring temporary relief to further dilatation.

Any stricture that will admit a filaform can be dilated without the use of any interurethral surgery. As the authors say, after cystotomy often a supposedly impassable stricture will admit a filaform; therefore we make it a rule to drain the bladder suprapubically in difficult cases, only attempting an external urethrotomy as a last resort.

❊

Doctor Parker (Closing).—Doctor Kreutzmann emphasizes the necessity of early cystotomy, following acute trauma to the urethra, male and female. Retrograding a catheter is sometimes indicated, but after a cystotomy has been performed, a "hands off" policy proves to be the best procedure in a large percentage of cases.

We recall one unusual case of severe pelvic injury where cystotomy was not done immediately in a male patient. Drainage of the bladder through an indwelling catheter resulted in finding the tip of the catheter in the left cotyloid cavity, due to a complete dislocation of the head of the femur. Incidentally, it may be mentioned that this condition was caused by a collision of an automobile and a switch engine.

Female urethral strictures other than traumatic seem to be confined to the meatal orifice. The element of spasm referred from the urogenital tract, pelvic pathology, lower colon and rectal pathology, always play a great part in changes that occur at the meatus. Once a change occurs in normal acidity of the vaginal secretions, there is a continuous irritation of the urethral orifice. As the decades of life progress, such changes of constriction, irritability, frequency, caruncles, and even to carcinoma, become more frequent.

It is our belief that the majority of the developments of such unfortunate entities are equally due to the above-mentioned pathology, plus false modesty on the part of the women in the third to the fifth decade of life.

Thorough examination, elimination of etiology, will be a great step toward the relief of a great class of women who suffer in silence. A simple posterior meatotomy with a small electric cautery has given many of these patients a future life of comfort. Surgically, a well-trained man can work with impunity on the female urethra so long as he has the proper respect for the vesical sphincter muscle.

MUSSEL POISONING*

By Hermann Sommer
and
Karl F. Meyer †
San Francisco

THE paralytic form of shellfish poisoning has been recognized as a distinct clinical entity for over a century.[1] It is to be distinguished from the allergic type, which affects only the people who are hypersensitive to the particular sea food, and it differs distinctly from the gastro-intestinal form, which is caused by spoilage of the mussels or pollution in the water. The symptoms of paralytic mussel poisoning are due solely to a neuropoison and consist of a tingling sensation in the extremities, followed by numbness, and in severe cases by complete paralysis and death within a few hours.

EPIDEMIOLOGICAL RECORDS

Although the malady has long been known, its cause is still veiled in darkness. One reason for this, undoubtedly, is the scarcity of its occurrence. In the European literature of the last one hundred years only about fifteen outbreaks have been recorded, with a total of some 120 cases and twenty-four deaths. Since all the mussels involved came from limited areas, such as estuaries or harbors, the assumption was natural that local factors, and probably land drainage, had something to do with the formation of the poison.

On the other hand, the recent outbreaks in California have afforded ample opportunities to gain a broader viewpoint and to add to the knowledge of this matter. The most extensive outbreak of mussel poisoning occurred near San Francisco in 1927, with 102 cases and six deaths. Others followed in 1929, 1932, 1933, and 1934, so that

* From the George Williams Hooper Foundation, University of California, San Francisco.
Read at the annual meeting of the American Public Health Association at Pasadena, September 3, 1934.
† Coworkers of the Experimental Part: R. Stohler, H. Mueller and W. F. Whedon.

TABLE 1.—*Epidemiology of Mussel Poisoning on the Pacific Coast, 1927-1934*

Area	1927	1928	1929	1930	1931	1932	1933	1934	Total
Central California	102 (6)		62 (4)*	2		40 (1)†	7		213 (11)
Northern California and Oregon							15 (1)		15 (1)
Alaska								12 (2)	12 (2)
Total	102 (6)		62 (4)	2		40 (1)	22 (1)	12 (2)	240 (14)

* Including six (three) cases of clam poisoning.
† Including three cases of clam poisoning.
Number of deaths in parentheses.

at present some 240 cases, with fourteen deaths, are on record. They all occurred between June and August, and resulted from mussels gathered between the Monterey peninsula and Fort Bragg, with a smaller outbreak in September, 1933, in the area between Crescent City, California, and Coos Bay, Oregon. Quite recently a report from Juneau, Alaska, indicates that several cases occurred, with two fatalities, in that neighborhood in July, 1934. All the mussels involved were freshly gathered along the open ocean shore, remote from stagnant or polluted waters, and were consumed fresh. The mussels having to do with one outbreak came from a coast line of over one hundred miles. These epidemiological records alone would demonstrate that any local factors or land drainage could not have been involved, but that mussel poisoning was more likely a marine phenomenon. (Table 1.)

PERIODIC LABORATORY TESTS

These contentions were fully substantiated and considerably extended through laboratory examinations started in 1927 and carried on to this date. One of the results is a poison curve for mussels from the vicinity of San Francisco, extending over a period of some seven years. As indicated in Figure 1, every year during the summer months the toxicity of the mussels rises to a peak, varying in intensity from year to year and making its reappearance some time between June and September. During some years the peak will reach the danger line; in others it will not. A comparison of the epidemiological data and the poison curve indicates a close correlation between the number of cases and the degree of toxicity of the mussels. This may be taken as a proof that the laboratory test, consisting of the intraperitoneal injection of a mussel extract into mice, gives an accurate measure of the toxicity of the mussels

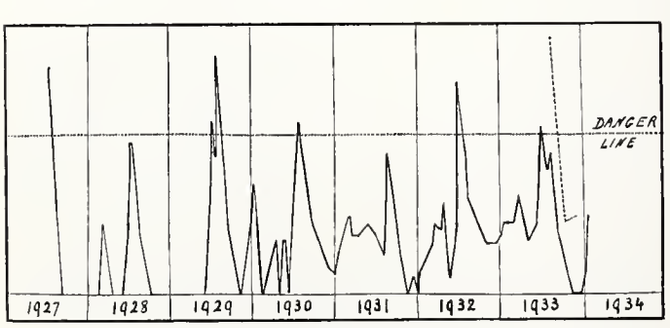


Fig. 1.—Toxicity of mussels near San Francisco.
(.....Northern California–Oregon.)

for humans. That the number of cases in the neighborhood of San Francisco has been steadily falling off is no sign of a decrease in toxicity, but indicates a more cautious attitude of the population in regard to the consumption of these shellfish. A second rise of lower intensity during the early spring months will be noticed. Furthermore, the decisive drop in toxicity to a minimum in late fall is noteworthy. At that time the poison may disappear entirely, or it may persist at a low level until the early spring of the following year. There are two phenomena, then, which need explanation: (*a*) the almost constant presence of minimal amounts of poison; (*b*) the strong increase in summer time. Both these findings are abnormal, since control mussels from La Jolla, San Diego, have never shown either of these characteristics. It is interesting to note, however, that poisonous mussels have been found not only along the coast from Monterey, California, to Coos Bay, Oregon, but also in samples received last year from Puget Sound, Washington.

SOURCE OF POISON

That shellfish poisoning is, indeed, a marine phenomenon was proved by further laboratory studies, together with field observations. It was found that mussels gathered at the lowest possible level are generally more poisonous than those growing higher up on the rocks. This disproves the popular belief that exposure to the heat of the sun is responsible for the production of the poison. A comparison of the various kinds of clams points in the same direction. It should be recalled that in August, 1929, three persons died from the consumption of Washington clams (Saxidomus nuttallii), gathered north of San Francisco. Tests showed that, of the dozen varieties of edible clams in this area, the most dangerous are the Washington and Horseneck clams, or those which receive the largest amount of fresh ocean water; while oysters and soft-shell clams (Mya arenaria), or those which grow in the quiet bay waters at a distance from the open ocean, are entirely harmless. This fact strongly suggests that the poison factor makes its appearance with the water. That the poison itself also disappears with the water is proved by the fact that poisonous mussels kept in the laboratory give off their toxin into the water, and lose one-half of their toxicity in about ten days. This decrease in toxicity is also noticeable if the mussels are kept in

a dry state, again refuting the argument that the harmful shellfish may have spoiled previous to consumption.

ADSORPTION OF MUSSEL POISON ON SAND

Attempts to demonstrate the poison itself in the water have long been unsuccessful. A better knowledge of its chemical characteristics finally helped to overcome the difficulty.[2] It was found that the poison may readily be removed from an aqueous solution by permutit. The fact that this synthetic silicate takes up only basic, organic as well as inorganic substances, proves definitely that the poison is of basic nature. This property was also of great help in the isolation of the substance from the water. Since the food of the mussel, the plankton, has long been under suspicion, large amounts of it were collected by filtration through plankton nets. The filter residue not only consists of plankton, but also of a large amount of microscopic sand, marine bacteria and detritus. Subsequently it was found that the sand contains a component which acts in a manner analogous to permutit, and which will take up the poison whenever it is in contact with its aqueous solution. It was natural, then, that the small amount of poison finally demonstrated in the water, *i. e.*, about a lethal mouse dose per bucket, was found adsorbed on the sand. Where it originally came from is still a matter of conjecture; it may have been contained in the plankton, or it may have been excreted by near-by mussels. What practical importance the floating sand may have as a carrier of the poison remains for further investigations.

PLANKTON COUNTS

Another possible approach to the study of the plankton in relation to the poison is, of course, the statistical method. Plankton counts, especially a detailed classification of all dinoflagellates, carried on for nearly three years, tend to show that several species of the genus Gonyaulax occur most frequently, and often in large numbers, just before and during the poison seasons. Besides, a physiological change in these organisms seems to occur frequently at about the same time, manifesting itself by a more intense pigmentation. While the ratio of the number of Gonyaulax to the degree of toxicity is by no means constant, it is not unlikely that a detailed study of these and other peridinials occurring at times in large numbers might yield interesting results.

DISTINCTION BETWEEN POISONOUS AND NORMAL MUSSELS

In this connection it should be recorded that during the poison period mussels are usually found with full intestinal tracts and enlarged digestive glands. This is of frequent, but by no means constant occurrence. In fact, there is not one characteristic which may be used as an absolutely sure distinguishing feature between normal and harmful bivalves. The general reactivity of the mussels, their respiratory quotient, the histological picture, the bacterial flora and protozoan fauna are some of the characteristics which have been studied and found more or less identical in the two groups of mussels. Unusual appearances along the ocean shore, like phosphorescence or "red water," have often been observed during the toxic season, but they cannot be relied upon as warning signals. The poison time falls in the summer months, when marine life is most intense and unusual phenomena are apt to make their appearance.

TOXICITY OF SAND CRABS

One of the unusual occurrences which was noticed for several years during the peak of the poison curve was the pronounced mortality of sand crabs. Subsequent investigation proved that these crustaceans are very nearly of the same toxicity as the mussels of the same locality at the same time.[3] They may be used, therefore, as test animals when mussels are not readily available. Although both the bivalves and the sand crabs are plankton feeders, the latter show some significant differences in their response to the substance. Sand crabs, with full intestinal canals, are as much as ten times more poisonous than those with empty digestive organs, indicating a rapid excretion of the poison. Furthermore, the crabs seem to be affected by some pathological condition which manifests itself in brown, melanin-like spots, around the joints of their legs. A detailed investigation of these conditions should be expected to help considerably in the elucidation of the problem.

With the help of the sand crabs, the widely held notion that the spawning of the shellfish is in any way involved in this problem may be readily disproved. The poison periods for the crabs and the mussels coincide, while their spawning seasons vary considerably. The sand crabs spawn mostly during the summer, while the mussels deposit their sex products in greatest numbers during the fall months, when the toxicity has subsided.

POTENCY OF MUSSEL POISON

It is strange that mollusks of such an intense toxicity that half a dozen of them are sufficient to kill a grown person should not show any outward signs of their poison. The explanation is that they contain a very small amount of an extremely toxic substance. Chemical studies have proved this. The purest preparations of poison so far obtained are lethal to mice in doses approaching one-millionth of a gram, on intraperitoneal injection. It is more active than any known chemical poison. Only the antigenic toxins of some plants and bacteria are more potent. In its action it resembles some of the most potent alkaloids. It acts quickly or not at all, and is rapidly excreted. It is not destroyed by boiling and not counteracted by any known drug.

PREVENTION OF SHELLFISH POISONING

Guarding against the poisoning is rather difficult. The best preventive method is education of the people in the collection and consumption of shellfish. The old saying that shellfish should be avoided during the months without *r* is

well founded, and September and October ought to be added also. Since practically all the poison is concentrated in the digestive gland of the shellfish, this organ should be strictly avoided. The broth, which naturally contains a good deal of the harmful substance, should also be discarded, at least during the summer months. It is doubtful whether any accidents would occur, even during the poison season, if only the light meat were consumed. A German investigator in 1885,[4] and recently a coworker in this laboratory,[5] have proposed that mussels be boiled for twenty minutes with the addition of sodium bicarbonate, which destroys most of the poison. This method is to be highly recommended from a chemical standpoint, less so from a culinary point of view. In California a seasonal quarantine on the sale of mussels, based on the present studies, has been found most expedient and undoubtedly has helped greatly in keeping the number of poison cases down to a minimum.

COMPARISON WITH SIMILAR POISONINGS

Mussel poisoning in itself would hardly warrant the time and energy spent in investigation of this sort were it not that a number of marine poisonings may be closely related to this problem in one or another of its aspects. They all have in common one characteristic: they are capricious in their appearance, and elusive. Fugu poisoning is caused principally in Japan by the consumption of the liver and sex products of Tetroden fish. It resembles mussel poisoning in that the active substance, although a sex poison, can hardly be distinguished chemically or toxicologically from the mussel toxin. The fish poison of the subtropical American waters, Ciguatera, is also of rare and elusive occurrence. The Haff disease, limited to a small number of localities of northern Germany, again made its appearance, after a lapse of several years, during 1933. It also occurs during the summer months exclusively and is caused by the consumption of eel and similar fish from the brackish waters of the Haff lagoons near Koenigsberg. Whether the explanation given at present by the German workers is correct, namely, that the sewage from the lumber and paper mills is to blame, remains to be seen. Last, but not least, the water-bloom poisoning, which has again been reported in recent years, especially from the lakes of Minnesota, must be mentioned, although it is of fresh-water origin. Cattle and other domestic animals may die in less than an hour after drinking from lakes which in summer are covered with the growth of blue-green algae. Here again an exceedingly potent substance, which is apparently liberated by some microörganism in the water, is to blame. Fitch, Gortner, and co-workers[6] have recently been able to demonstrate the poison in solution in the water.

CONCLUSIONS

Although the results of these studies are very incomplete, so far as the origin of this strange poisoning is concerned, the following conclusions seem justified. Mussel poisoning is definitely of marine origin. It has occurred for centuries, in the waters of the northern temperate zone, and it will undoubtedly occur again. There is nothing that can be done about it other than to study its peculiarities and guard against its effects. It is of rare occurrence, and experiences gained during the life of one generation have usually been forgotten by the next. It is hoped that the results of these studies will have thrown at least a little light on this interesting field of marine toxicology.

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SIGHT-SAVING CLASSES*

By Frank H. Rodin, M. D.
San Francisco

Discussion *by Frederick C. Cordes, M.D., San Francisco; W. Morton Gardner, M.D., Los Angeles; George H. Kress, M.D., Los Angeles.*

THE majority of the medical profession, including many eye physicians, are not aware of the purpose of sight-saving classes, although they have been established in the United States since 1913. At present, there are over four hundred and thirty such classes, with an enrollment of over six thousand children.

Sight-saving classes are primarily for children whose vision is so impaired that they are unable to be educated in the regular classrooms, or their training is accomplished at the expense of their already limited vision. Children who are blind are educated, of course, in the schools for the blind.

CHILDREN ELIGIBLE FOR SIGHT-SAVING CLASSES

The children eligible for such classes are usually those whose vision is between 20 and 70 per cent in the better eye (between 20/200 and 26/60 vision, by Snellen's chart measurement); children who have a high myopia, where the myopia is over six diopters, or where there is a rapid progress of the myopia; or any child whose vision is such that he is unable to be properly instructed in the ordinary grade.

Under a specially trained teacher, a sight-saving class is set apart in the regular school building. Such a room should have a good eastern exposure to give the maximum of light with the minimum of glare. It should be equipped with special artificial light to be used on dark days. Large-sized type books are used. Slightly rough and unglazed Manila paper is employed for writing, and the

* From the Bureau of Child Hygiene, San Francisco Department of Public Health. J. C. Geiger, M.D., Director of Public Health.

pencils have soft, thick, heavy lead. The children in the fifth grade are taught to use the typewriter by the touch system. Oral teaching is done as much as possible. The pupils recite all oral work in the ordinary classes, but the written work is done in the special class, with the special sight-saving tools, under the guidance of the teacher.

These classes are usually limited to a small group of children, from twelve to fifteen in number.

A description of the children attending such a sight-saving class in an elementary school will illustrate its purpose and its value.

The following histories are taken from the eye physicians' reports which are requested for each child.

HISTORIES OF CHILDREN IN AN ELEMENTARY SIGHT-SAVING CLASS

1. Nystagmus. G. M., boy, age six years, has been attending sight-saving class for a year. Vision: right eye, 70 per cent; left, 65 per cent.

2. Degenerative changes of the maculas. Mixed astigmatism. Left eye: Convergent strabismus. C. E., boy, age eight years, attending class two months. Vision: right eye, 33 per cent; left, 4 per cent.

3. Congenital cataracts. Operations. W. D., boy, age eight years, attending class one year. Vision: right eye, 50 per cent; left, 50 per cent.

Previous to his entrance to the sight-saving class he could do nothing in the regular grade. At present he is able to do the class work required for his age.

4. Microphthalmi. Malformation of the retinas. T. M., boy, age eight years, attending class three years. Vision: right eye, 10 per cent; left, 4 per cent.

It is remarkable what progress this boy has made since his entrance into the sight-saving class. His whole personality has changed, and he is doing the required work for his grade.

5. Compound hyperopic astigmatism. R. H., boy, age nine years, attending class six months. Vision: right eye, with + 3.00 sph. ⌒ + 2.50 cyl. axis 100° = 90 per cent; left, with + 3.00 sph. ⌒ + 2.50 cyl. axis 80° = 90 per cent.

This boy was unable to do much work in the regular classroom. He was constantly complaining of severe headaches and difficulty in reading for any length of time. Since attending the sight-saving class he is able to do his work with complete comfort.

6. Right eye: Nystagmus and myopia. Left: Congenital glaucoma. Iridectomy. Phthisis bulbi. M. D., girl, age nine years, attending class two years. Vision: right eye, with — 6.00 sph. = 20 per cent; left, blind.

Since attending the sight-saving class, she is learning to read and add numbers. She could do nothing in the regular class.

7. Compound hyperopic astigmatism. B. F., boy, age nine years, attending class six months. Vision: right eye, with + 4.00 sph. ⌒ + .50 cyl. axis 105° = 20 per cent; left, + 3.50 sph. ⌒ + .75 cyl. axis 75° = 75 per cent.

At the regular school, his work had been very poor; but since entering the special class there has been marked improvement.

8. Right eye: Congenital amblyopia. Left: Congenital cataract. Operation: Blindness. C. E., girl, age nine years, has been attending class two months. Vision: right eye, 50 per cent; left, blind.

Her school work was poor when she attended the regular class, and she was absent most of the time because she could not see well. At present she is very happy and is doing good work.

9. Congenital cataracts. Operations. Microcorneas. B. S., girl, age nine years, attending class nine months. Vision: right eye, 10 per cent; left, 15 per cent.

This child had never been in school, because of poor vision, before entering the sight-saving class. She is now doing third-grade work.

10. Progressive myopia. M. F., girl, age ten years, attending class one year. Vision: right eye, recognition of fingers at ten feet, with — 5.00 sph. = 90 per cent; left, recognition of fingers at ten feet, with — 5.50 sph. = 90 per cent.

This girl's myopia progressed considerably during the last two years.

11. Retinochoroiditis. Left eye: Internal strabismus. C. L., girl, age ten years, attending class two years. Vision: right eye, recognition of hand movements, with her glasses = 15 per cent; left, recognition of hand movements, no improvement with her glasses.

12. Chronic iridocyclitis: Secondary cataracts. O. M., boy, age eleven years, attending class three years. Vision: right eye, 33 per cent; left, recognition of fingers at one foot. The irises are atrophic and adherent to secondary membranes in the pupillary areas.

In spite of his poor vision, he is doing excellent work.

13. Mixed astigmatism. R. O., boy, age eleven years, attending class eight months. Vision: right eye, with + 1.00 sph. ⌒ — 4.00 cyl. axis 45° = 50 per cent; left, + 1.00 sph. ⌒ — 4.00 cyl. axis 50° = 75 per cent.

14. Compound hyperopic astigmatism. M. N., girl, age eleven years, attending class four months. Vision: right eye, with + 3.00 sph. ⌒ + 3.00 cyl. axis 90° = 20 per cent; left, + 4.00 sph. ⌒ + 2.00 cyl. axis 90° = 20 per cent.

She was unable to do any work in the regular grade, due to her poor vision.

15. Chronic iridocyclitis: Complicated cataracts. H. M., girl, age twelve years, attending class four years. Vision: right eye, 63 per cent; left, 40 per cent. The corneas are hazy, due to fine opacities.

This girl was a truant case: her reason for not attending school was that she did not see well. Since attending the sight-saving class, she has been doing good work and is ready to enter Junior High School.

16. Compound hyperopic astigmatism. W. H., boy, age twelve years, attending class six months. Vision: right eye, with + 3.00 sph. ⌒ + 3.50 cyl. axis 100° = 75 per cent; left, with + 3.00 sph. ⌒ + 3.50 cyl. axis 80° = 75 per cent.

The above boy and the one reported in Case 5 are brothers. Both complained that while attending regular classes they were subject to severe headaches, especially when trying to do any reading. Since attending the sight-saving class, they are free of complaints and are capable of doing with comfort the

school work required of them. Both parents of the boy and their families have high refractive errors with poor visual acuity.

17. Congenital dislocation of lenses. Central choroiditis. L. L., boy, age twelve years, attending school three years. Vision: right eye, 80 per cent; left, 80 per cent.

18. Hyperopic astigmatism. W. C., boy, age thirteen years, attending school four years. Vision: right eye, 20 per cent, with + 1.25 sph. ⌒ + 5.75 cyl. axis 90° = 90 per cent; left, same as the right.

This boy could do very little work in the regular class and was a discipline problem. He used to complain of a great deal of eye discomfort. Since attending sight-saving class his work is fair and his deportment has improved.

19. Compound hyperopic astigmatism. Right eye: ptosis upper eyelid. Internal strabismus. H. L., boy, age fourteen years, attending class seven years. Vision: right eye, with + 1.00 sph. ⌒ + 3.00 cyl. axis 80° = 50 per cent; left, with 1.00 sph. ⌒ + 3.00 cyl. axis 80° = 75 per cent.

The boy's mental age is nine years six months (Stanford-Binet test) and his intelligence quotient is seventy-one. He is a borderline case, closely approximating mental deficiency. He was sent to the sight-saving class because it was thought that his poor vision might be a factor in his poor class work. There has been no improvement in his mentality. However, he has gained more than he would have acquired in a regular classroom, and he is to enter Junior High School next term.

COMMENT

This special class has an enrollment of nineteen children, rather a large number for such a class. This is partly due to the fact that nine children enrolled during the last year.

There are only two children with high myopia present in the class, which is much less than the number usually found in a sight-saving class. About one-third of the children enrolled in a sight-saving class have high myopia.

In the Junior High School sight-saving class of this city, where the enrollment is fifteen, the number of children with high myopia is seven.

It is evident from the histories of the children enrolled in the sight-saving class that, with their various visual handicaps, they can receive very little training while attending the regular classes. In a sight-saving class, on the other hand, these children have the same opportunity for education as children with normal vision.

The children are recommended for entrance to a sight-saving class either by their attending eye physician or through the inspection conducted by school medical examiners.

Apparently, very few of the eye physicians and general practitioners realize the opportunity for the education of a visually handicapped child, as very few of these children have been recommended by them.

The majority of the children enrolled have been found by the medical examiners, or by the school teachers who observed, that the child had poor vision and requested an examination of the eyes by a school medical examiner.

SUMMARY

1. Sight-saving classes are for children who are visually handicapped.

2. The histories of nineteen children attending a sight-saving class are given.

3. None of these children are capable of receiving the usual school education in the regular classrooms.

4. The medical profession, especially the eye physicians, should consider the hinderments to education of the children whom they find to have poor vision; and children whose vision is so poor that they are unable to be instructed in the regular classrooms should be recommended for admission to a sight-saving class.

5. It has been estimated that in the United States one child out of five hundred (or a thousand) has a visual handicap, and should attend a sight-saving class.

490 Post Street.

DISCUSSION

Frederick C. Cordes, M. D. (384 Post Street, San Francisco).—Doctor Rodin's paper is timely in that it again calls to the attention of the medical profession the existence of sight-saving classes. He has been interested in this work for a number of years and has done a great deal to establish these classes in San Francisco on their present high plane.

These children with poor vision are a definite problem. Because of their visual handicap, it is impossible for them to keep up with the normal school work of children of their own age. In attempting to do this they are often looked upon as dull children and are frequently "guyed" by their classmates. Thus, such a child is frequently very unhappy, and early develops an inferiority complex.

In these special sight-saving classes, such children are given training commensurate with their vision. Before they are enrolled, a complete report of the eye condition is obtained from the ophthalmologist. His advice as to the amount of eye work permitted is sought and his suggestion is carefully followed. Therefore, these children are cared for as individuals and not as a group. Upon completion of their school work they are able to be self-supporting individuals rather than dependents. They are not to be confused with the blind, who are unable to do many things accomplished by this group having defective eyesight.

As Doctor Rodin points out, either most eye physicians are ignorant of this work or do not take the necessary time to explain its purpose to the parents of such children. A short time ago I saw a boy of six who had a marked congenital nystagmus with amblyopia and vision of 20/200 in each eye, with correction. At the completion of the examination, I explained the situation to the mother and talked to her about the conservation-of-vision class. She was delighted to know that something could be done. The boy's twin sister did not have this defect, and the mother had been worried some time, realizing that he would be unable to keep up with her. This patient had been seen by three oculists, none of whom mentioned the possibility of special training for this child with defective vision.

As stated above, I feel that Doctor Rodin's paper is very timely, and it is to be hoped it will call to the attention of the medical profession this very important and often neglected phase of our work.

W. Morton Gardner, M. D. (5514 Wilshire Boulevard, Los Angeles). — In discussing Doctor Rodin's paper concerning sight-saving classes, I would simply emphasize certain points.

To begin with, Doctor Rodin's comment concerning the attitude of physicians, even oculists, toward sight-saving classes is timely. We ophthalmologists are prone to be jealous of our results, and are reluctant to admit that we have not afforded our patients 6/6 vision. We proudly call the attention of the parent to a gain of at least from 6/60 to 6/30, forgetting that 6/30 vision still leaves the child educationally handicapped. Again, believing that the use of the eye will improve its visual acuity, some advise regular class work in school, not realizing that our modern public school curriculum spells *excessive use* of the eyes, or *strain* to the child with defective vision.

We do not ask the athlete to begin with the impossible to train to do his best.

Placing a child in a sight-saving class does not diminish his vision. It does diminish the *abuse* of his vision. He obtains his education with greater ease and does not mortgage his future vision, but retains it for later industrial use and enjoyment.

It may be that we of today are too paternalistic. There is a question whether we gain socially or economically in trying to educate the moron. But the nineteen cases reported by Doctor Rodin are representative of hundreds of children who have demonstrated that special attention to the physically handicapped, even the subnormal mentally (No. 19) has unquestioned social advantages. Moreover, we should be careful in classifying as subnormal mentally a child who does not measure up by an intelligent quotient test and who, at the same time, is handicapped physically. As Dr. Don Flagg has so frequently pointed out it may be a case of "mental retardation from deprivation of a special sense," which should solicit our sympathetic assistance, even though it may injure our professional pride that our patient has to attend a sight-saving class.

It is a pathetic picture—the visually handicapped child left in the regular grades to fight his way against terrific odds; yet how quickly we protest if an athlete is handicapped by the slightest injustice.

One of the crying needs of the day, therefore, is greater sight-saving class facilities. With an enrollment of 200,000 in the first eight grades of our Los Angeles city schools, according to estimates there are probably four hundred children in these grades with vision so poor as to require special aid in order to obtain their education in a reasonable time, if at all. We have, however, less than one hundred in our elementary grades assigned to sight-saving classes, and about thirty in junior high grades. Probably other cities have a similar deficiency. Greater concern for the education of their patients on the part of oculists and better coöperation with the school physician, who well appreciates these facts, might mitigate this wrong.

I commend Doctor Rodin for his timely presentation of the facts with typical cases as proof.

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George H. Kress, M.D. (945 Roosevelt Building, Los Angeles).—Of the twenty-five million school children in our country, about three million have visual defects of sufficient amount to become, if not corrected, handicaps during and after school years. Children with deficient vision of a degree sufficient to place them in what is known as the partially-seeing group should be sent to sight-saving classes. Doctor Rodin has indicated the types and degrees of visual deficiencies which give the indications for transferring children from ordinary classrooms to the sight-saving classes. A perusal of the case reports which he submits makes understandable the reasons why society, because of the physical and emotional factors involved, is obligated to aid such children. The care of those thus embarrassed is a problem worthy of the serious attention of physicians, because the future happiness of these future citizens is determined, to a large extent, by the means taken to educate them during their school years. Children with such visual defects are handicapped not only in ordinary school work and in play, but often in their homes; and so much so that they can easily develop inferiority complexes, and occasionally, through egotism in the possession of an unusual physical deformity, superiority or extrovert complexes.

It is heartening to know that almost five hundred sight-saving classes are maintained today in about 150 different communities. It is true that this provides for only a small percentage of the fifty thousand or so children in the United States who need this special sight-saving training, but it is a real and much needed beginning. It is gratifying, also, to know that San Francisco, Los Angeles, and other cities are among the progressive centers which have inauguraed such training in California. We suggest that California communities in need of sight-saving classes ask Doctor Rodin to aid them in the solution of their problems.

ENCEPHALOGRAPHY IN CHILDREN*

By F. G. Lindemulder, M. D.
San Diego

Discussion *by Howard Fleming, M.D., San Francisco; E. B. Shaw, M.D., San Francisco; Mark Albert Glaser, M.D., Los Angeles.*

IT has been just during the past few years that encephalography has become a common adjunct of the neurological examination. Only recently has its use been extended appreciably to the realm of pediatrics. Its value lies chiefly in the diagnostic field, although it has been found to have a therapeutic value as well. The encephalogram checks the clinical diagnosis and is an aid in demonstrating to the physician, as well as to the relatives of the patient, the organic change that has taken place in the brain. Therapeutically, the procedure may have a favorable effect in cases of concussion headache, traumatic encephalitis, and the epilepsies, especially those due to encephalitis.

INDICATIONS AND CONTRA-INDICATIONS

Encephalography is not a procedure to be recommended lightly without regard to the type of case. It is dangerous in cases of tumor of the posterior fossa, unless the fluid is drawn off slowly and the air injected at intervals following the removal of small quantities of cerebrospinal fluid. It is positively contraindicated, in my opinion, in the presence of an infection either in the blood stream or in some focus near the cranial cavity. Under such circumstances, I have seen the removal of spinal fluid followed by the development of a meningitis which, I feel sure, would not have occurred if the infection had not, so to speak, been drawn into the central nervous system. Aside from these two considerations, however, it may be looked upon as a harmless procedure.

ANESTHETIC

I prefer an inhalation anesthetic for making encephalograms in children, because of the difficulty in obtaining coöperation, and the possibility that the child may move and break the lumbar puncture needle. It has been my custom, there-

* From the Rees-Stealy Clinic.

Read before the Pediatric Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.



Fig. 1



Fig. 2

Fig. 1.—Subarachoid space over right cerebral cortex demonstrates little if any air as compared with the left. The ventricular system is of normal size and position. Case of adhesive arachnoiditis following subarachnoid hemorrhage.

Fig. 2.—External hydrocephalus resulting from birth injury. The ventricular system was not visualized.

fore, to use ether anesthesia. Others, however, have had good results with barbituric acid preparations, avertin, morphia, etc.

WITHDRAWAL OF THE CEREBROSPINAL FLUID

In withdrawing the cerebrospinal fluid and injecting the air, it is best to replace each five cubic centimeters of fluid removed with the same amount of air. The total amount of air injected equals the total amount of fluid removed; and this varies with the individual patient and the type of brain disturbance. I feel that 150 cubic centimeters of air are sufficient to make an accurate diagnosis; occasionally, in cases in which it was possible to inject only 60 cubic centimeters of air, this amount was found, surprisingly, to be sufficient for diagnosis.

PROCEDURE IN TAKING THE ENCEPHALOGRAM

For taking the encephalogram, a special chair such as has been described by Camp and Waggoner, and others, or an operating table may be used. At the beginning of the procedure the patient may lie on his side; but it is soon necessary to place him in a sitting posture in order to obtain sufficient flow of the cerebrospinal fluid. The patient then remains in the upright position until after the roentgenograms are taken. This prevents a shift of air, which might cause difficulty in the interpretation of the films.

The encephalogram not only may show the location and size of the ventricles and cisterns, but also, since the air spreads over the cortex as well, may demonstrate the presence of cortical atrophy, subdural growths and hemorrhages. Therefore, the x-ray films should include at least anterior-posterior, posterior-anterior, and right and left stereo positions of the skull.

REPORT OF CASES

The following brief case reports illustrate the information that may be obtained from the encephalogram:

Case 1.—A child, aged four years, was brought to the hospital by the parents because of convulsions. The neurological and physical examinations failed to show any evidence of organic disease. The encephalogram (Fig. 1) disclosed that there was little, if any, air over the right cerebral cortex as compared with the left, whereas the ventricular system was of normal shape and position. This finding indicated that, at some time, the patient had probably had a subarachnoid hemorrhage, which resulted in an adhesive arachnoiditis. This arachnoiditis was probably causing enough irritation to produce the convulsive state.

* * *

Case 2.—A female patient, aged 24 years, had received a cerebral injury at the time of birth, which, when we saw the patient, was manifesting itself clinically as a left hemiplegia. The encephalogram (Fig. 2) showed no air in the ventricular system and a marked external hydrocephalus, particularly on the left.

* * *

Case 3.—The third case was that of a girl, 15 years of age, who, four weeks prior to the taking of the encephalogram, had had a basilar skull fracture. The patient complained of terrific headaches and was unable to talk. The roentgenograms (Figs. 3 and 4) demonstrated the ventricular system exceptionally well, but no air was seen over the cortex of the brain. This finding indicated a diffuse hemorrhage over the entire cerebral cortex, which occluded those subarachnoid spaces.

IN CONCLUSION

Encephalography marks a definite step forward in the progress of medicine. It is of value as an aid in diagnosis and prognosis, and it constitutes a form of therapy in certain selected cases of brain disturbance.

2001 Fourth Avenue.

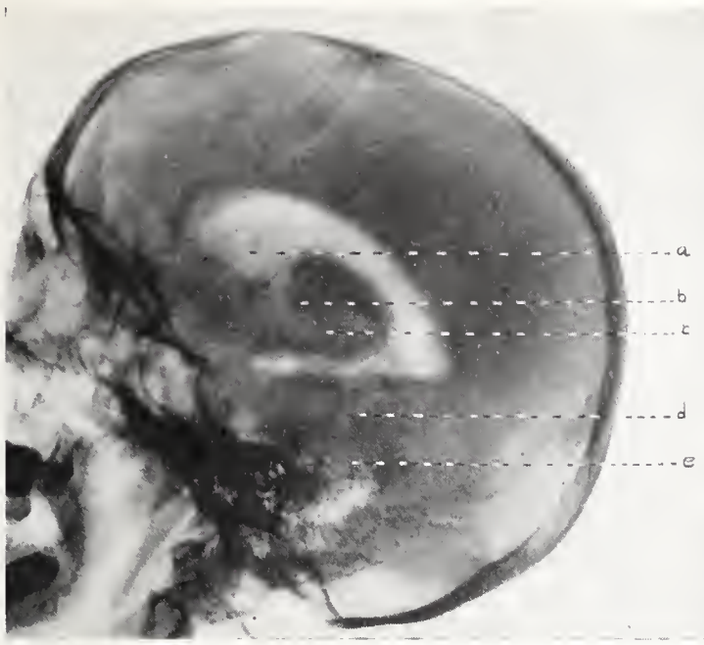


Fig. 3



Fig. 4

Fig. 3.—An unusual demonstration of the ventricular system. No air is seen over the cortex of the brain. (a) Lateral ventricles; (b) Middle commissure; (c) Third ventricle; (d) Aqueduct of Sylvius; (e) Fourth ventricle.

Fig. 4.—PA view of Figure 3, showing no deviation of ventricular system and no filling of subarachnoid spaces over the cortex of the brain with air. This is a case of subarachnoid hemorrhage following basilar skull fracture.

DISCUSSION

Howard Fleming, M. D. (384 Post Street, San Francisco).—Doctor Lindemulder's paper, emphasizing the value of encephalography as a diagnostic measure, is most timely. Visualization of the size, form, and position of the ventricle and subarachnoid spaces will often give valuable information as to the intracranial pathology. This is particularly true in patients suffering from convulsions. Only too frequently patients are treated for idiopathic epilepsy without proper investigation. Encephalograms often reveal unsuspected pathology in such cases.

The procedure is attended with a slight amount of risk. This is especially true in elderly patients with advanced arterial changes and in patients with signs of increased intracranial pressure. Symptoms or signs of the posterior fossa lesion are definite contraindications for encephalography. In these cases the introduction of air directly into the ventricle is the method of choice.

The technique of encephalography is not standardized. Most surgeons prefer to carry out the procedure with the patient anesthetized and in a sitting position. In our experience, the use of two needles in the lumbar spaces adds to the safety of the procedure, and gives a greater percentage of satisfactory results. Recently the use of gases other than air, as reported by Dr. Robert Aird, promises a marked improvement, particularly as to the reaction on the patient.

The interpretation of the films is the most important part of the test. Wide variations from normal offer no difficulty, but frequently the changes are slight. The most meticulous attention to detail must be used in taking the film, if error in diagnosis is to be avoided. Improper position of the head or misdirection of the ray will often eventuate in films that suggest pathology and may be most misleading.

Encephalography is a diagnostic help only and must be correlated with all other information to be obtained. Cases for its use must be selected carefully. Indiscriminate use of encephalography might very well serve to discredit this most valuable diagnostic aid.

❊

E. B. Shaw, M.D. (384 Post Street, San Francisco). Visualization of intracranial conditions is a valuable adjunct to the usual methods of anatomic diagnosis of the diseases of the central nervous system in childhood. Encephalography not only accomplishes visualization, but sometimes affords surprising therapeutic effects. It is of especial value in conditions involving cerebral birth accidents and congenital defects of brain development.

Despite the value of the method, the precautions and contraindications mentioned should be weightily regarded. The procedure is not intricate, but its employment, and particularly the management of its complications, requires a trained neurosurgical technique. The interpretation of results is not altogether simple, and training and experience are necessary lest artifacts be interpreted as true anatomical lesions.

This paper has been presented to pediatricians, and it behooves us to employ the method as indications arise. Few of us, however, possess the requisite training, or encounter a sufficient number of cases to enable us to perfect a technique of performance or the interpretation of results.

As a final word of caution, it might be proposed that encephalography be not regarded as a pediatric procedure, but should preferably be delegated by the pediatrician to those who have adequately perfected their methods, are sufficiently skilled in interpretation of results, and are prepared to carry out such further steps as are indicated or necessitated by this diagnostic procedure.

❊

Mark Albert Glaser, M. D. (727 West Seventh Street, Los Angeles).—Doctor Lindemulder has clearly emphasized the importance of encephalography as a diagnostic procedure. Furthermore, he has definitely stated that this method of diagnostic procedure is not without risk. The mortality in encephalography carried out in the proper hands is about one-quarter of one per cent. The encephalogram is not only of diagnostic value, but in certain cerebral cases is a valuable therapeutic adjunct.

Encephalography should not be looked upon as a terrifying procedure, and valuable information which can be obtained from such procedure should be a matter of common knowledge.

By the encephalogram we are able to visualize changes in the ventricles as to size and shape, and abnormalities in the subarachnoid space, such as adhesions or atrophic areas, may be observed. Therapeutically, convulsive states have been benefited;

post-traumatic headaches have been relieved and the adhesions from meningitis have been eliminated. Furthermore, convulsive states secondary to brain tumor have been accurately diagnosed, and in cases of birth trauma some prognosis as to the exact amount of damage, as well as the future of the child, can be arrived at. In other words, the procedure is definitely indicated in obscure neurological diseases wherein a clinical diagnosis cannot be accurately made or when brain tumor is suspected. This procedure has definite contraindications, as pointed out by Doctor Lindemulder; and in such cases wherein an outline of the brain is desired, ventriculogram is indicated.

I have enjoyed hearing Doctor Lindemulder's paper and I want to congratulate him on simplifying a subject which has heretofore been looked upon as technical, dangerous, and uninteresting.

RECONSTRUCTIVE PLASTIC AND ORAL SURGERY*

By Arthur E. Smith, M. D.
Los Angeles

Discussion *by William S. Kiskadden, M. D., Los Angeles; Francis L. Anton, M.D., Los Angeles; George Warren Pierce, M. D., San Francisco.*

THE recent economic crisis has brought to our attention an urgent demand for reconstructive surgery. Competition for a chance to start in the business world, more so to maintain a position therein, is so keen that one handicapped by a physical deformity must show a prodigious mentality to be considered. These unfortunate people are innocent victims of circumstance; who are often objects of pity and may even evoke the aversion of their friends. They are prone to become recluses and live somewhat like the marked introvert. They may not become efficient in even the most simple lines of endeavor, resulting in a condition which leads to the establishment of an inferiority complex. Why should we, as medical men, permit such a situation which can so easily be prevented by reconstructive plastic surgery!

There has been a definite trend in our modern civilization towards accentuating beauty in all forms of commercial industry, as is represented by architecture, municipal planning, automobile and aeroplane designing, and even in our personal stationery. This trend, whether or not admitted by the critic, certainly stands out as a definite fact. Employers show a marked tendency to select only those individuals who are personable as well as capable. We, in this community, are particularly confronted with countless demands for the correction of those defects which are magnified by the camera in one of our largest industries, the production of motion pictures. One can readily appreciate the personal economic value of the correction of a slight deformity which may bar chances for advancement in a chosen field. Defects should be corrected in the formative years, thus assuring better results from a cosmetic and psychological standpoint. Observations in the streets, the theatre or the schools evidence the truthfulness of this statement.

*Read before the General Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

THE FIELD OF PLASTIC SURGERY

The field of plastic surgery which rightfully belongs to the medical profession has been invaded, not only by quacks and charlatans, but by unethical and ill-prepared practitioners as well. By means of unscrupulous and flagrant advertising, these people have placed themselves before the public eye as the ultimate need of anyone seeking beauty or health. This, coupled with the bad results of their "curative art," is exemplified by the fact that we have, in our court records, examples of people seeking redress for the often irreparable damage that they have done. Consequently, the public has a mistaken idea of plastic surgery, and a disrepute has been imposed on this specialty. It is the responsibility of organized medicine to educate the public to the real value and work of the ethical plastic surgeon who is respected by his colleagues.

Many have incorrectly considered plastic surgery to be entirely a development of the recent war. While the progress of reconstructive plastic surgery since that time has been great, literature reveals that successful plastic operations were accomplished centuries ago. Attention was called to this fact in a paper read before the American Surgical Association in 1925, by Dr. John Staige Davis, plastic surgeon at Johns Hopkins University. Tagliacozzi, in 1597, was the first to write a book on plastic procedures, but there were earlier reports of plastic surgery of the face by Benedictus in 1492. The technique as described by Tagliacozzi was forgotten until the eighteenth century, when it was enthusiastically revived by many surgeons who recognized the value of this specialized branch of general surgery.

INFLUENCE OF THE GREAT WAR ON PLASTIC SURGERY PROCEDURES

The volume of deformities resulting from the recent great war stimulated the establishment of many procedures of plastic surgery which previously were merely experimental. Among the methods of modern advancement, the writer desires to place special emphasis on the value of Gillies' tubed pedicle, the use of a modeling compound method in the application of the Thiersch-graft, the application of mechanical principles in splinting and moulding the tissues, and the cartilage transplant. Plastic surgery of the face and the tissues involving the oral cavity is one of the most difficult branches of surgery from the standpoint of cosmetic appearance and restoration of normal function, frequently in the presence of infection.

THE AUTOMOBILE A CAUSATIVE AGENT IN FACE DEFORMITIES

The automobile is possibly the greatest factor in producing deformities of the face, especially the nose and jaws. Present day sports, such as boxing, wrestling, football, basketball and swimming, often result in broken noses and jaws, torn and lacerated facial tissues, formation of cauliflower ears, all of which demand repair. Efficient

first-aid surgery does not in most cases produce the desired functional and cosmetic result. Plastic surgery is useful for the removal of scar tissue, especially following destructive action of second and third degree burns, which have produced an unpleasant appearance or impaired function. Reconstruction is needed for the removal of keloids, to correct an unsightly ectropion, or a facial deformity resulting from paralysis of the facial nerve. The restoration of normal functions to children afflicted with congenital cleft palate, and cleft lip, is a credit to plastic surgery. The successful accomplishments of restoration, transplantation and reconstruction of tissues have been so great during the past decade that the larger medical schools throughout the country have established departments of reconstructive plastic surgery.

FIELDS OF APPLICATION IN FACIAL DEFORMITIES

Destruction of facial contours caused by depressed fractures of the malar and superior maxillary bones may be restored to normal. Acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected. Abnormal inverted or everted eyelids, closure of the palpebral opening, drooping of the upper lid, and the presence of a fold of skin extending over the inner angles of the ocular openings, are some of the defects of natal origin which come to the surgeon's attention. Eyebrows can be replaced. Certain unsightly discolorations of the skin resulting from congenital lesions, or those acquired by tattooing, gunpowder and certain chemicals can easily be removed. Included in the field of plastic surgery are the reduction of hypertrophied lips; an ear may be restored or rebuilt by using a metal mould; protruding jaws reduced; reconstruction of secondary deformities produced by badly designed lip closure; restoration of philtrum, cupid's bow and vermilion border line; application of Thiersch-grafts on moulds for the restoration of buccal and labial oral sulci due to obliteration by scar tissue, thus making it possible for patient to wear a dental plate; alveolomerotomy, operation for reduction of upper edentulous jaw protrusion for dental prosthesis construction; for the removal of scar tissue causing a distorted socket and placing of new conjunctional fornices capable of carrying an artificial eye; the application of a Thiersch-graft on a thin mould in symblepharon; the rebuilding of an upper or lower lip; the closure of chronic ora-antral sinus; for skin grafting; following the removal of scars which prevent normal movement of joints caused by burns or extensive trauma; for the bony reconstruction of the lower jaw and the establishment of normal facial contour and profile of the soft tissues.

THE NOSE IS IMPORTANT AS A BASIS FOR GOOD APPEARANCE

We believe that the nose is the basis of good looks. Cosmetic indications for the correction of an awry or deformed nose must not be undervalued, and impaired breathing must be given great consideration. It is believed that trauma is the causative factor in at least 75 per cent of these cases. Injury may antedate the patient's memory, for the developing bone and cartilage in early childhood are very tender, and even a slight blow may produce displacement of the nasal bones or deviation of the nasal septum. Such abnormalities cause mouth breathing, which may result in irregular, unerupted or impacted teeth, the formation of abnormal dental arches and protruding jaws. Displaced, undeveloped nasal bones or an injured septum may continue to ossify at a vicious angle. Trauma to the nose in early childhood appears to cause less fibrous adhesions and exostoses than trauma in later life.

RECONSTRUCTIVE SURGERY IMPLIES INDIVIDUALIZATION

Reconstructive surgery requires skillful care. No two cases being similar, each must be studied individually and the technique for reconstruction must be carefully outlined and planned prior to operation, if efficient results are to be attained. Photographs of each patient should be taken and preoperative models made. The author has perfected a plastic compound for the making of the negative or mould, which has proven satisfactory because the most exacting detail is reproduced on the positive, or model. This compound is so light and free from irritating qualities that a face mask is taken with the patient's eyes open without producing the slightest irritation to the conjunctivae. It is neither cohesive nor adhesive, making possible its application and removal from eyebrows and lashes without producing discomfort. The positive, which is capable of recording the most minute detail contained on the negative or mould, is very hard, does not expand or contract, is flesh colored in appearance, and is not porous, making it ideal for actual color reproduction of lesions. The face mask or oral impression, if carefully made, will produce an accurate reproduction of the part to be operated. Such lesions as a scar, cleft lip, cleft palate, deformed ear, nose or jaw, can be accurately duplicated in model form. These models are valuable in planning the operation and in the construction of case splints and the outlining of flaps, and for the moulding and reshaping of tissues, in order to restore correct anatomic form, outline and function.

Not only are accurately made models and sharply detailed photographs important preoperative adjuncts, but they are also invaluable as permanent records. In addition, they afford a comparison between the preoperative condition and the results of reconstruction. Obviously, photographs should never be retouched, because the detailed results of the surgery would be camouflaged, and thereby, rendered unscientific.

EFFICIENT SURGICAL TECHNIQUE IMPLIES APPLICATION OF PROPER MECHANICAL PRINCIPLES

Success attained from plastic surgery is perhaps due equally to efficient surgical technique and the proper application of mechanics in construc-



Fig. 1

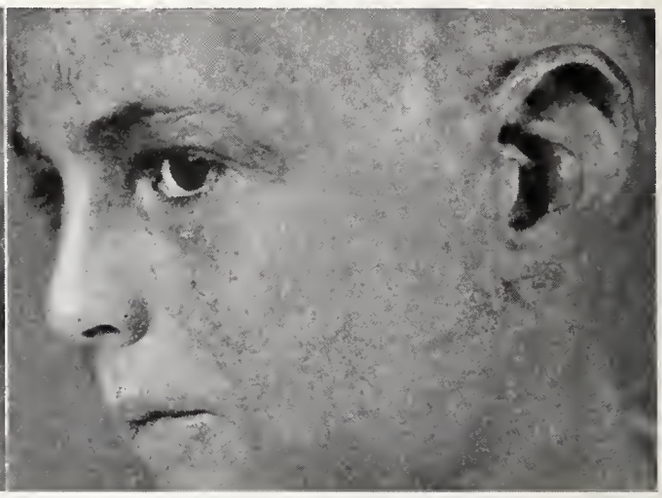


Fig. 2

Fig. 1 (Case 1).—Excessive scarring of left ear and cheek resulting from third degree burns caused by ignited gasoline, followed by keloid formation. Cartilage was involved. The right ear and cheek also badly burned.

Fig. 2 (Case 1).—Illustrating the result obtained from reconstructive surgery followed by x-ray and radium therapy treatments.

tion of patterns and moulds, with the making of definite plans of the operation before the time of actual surgery. Accurate patterns may be constructed of thin rubber, if the operation is to be on the skin surface; of metal if the operation involves transplantation of cartilage or bone. These models, which are sterilized and used at the operating table, should be carefully prepared in order that the cartilage, bone or soft tissues can be properly shaped before being transplanted to the operative field.

The greatest enemies to the plastic surgeon are sepsis, formation of keloids, and inadequate blood supply. A necessity in keeping scars to a minimum is the proper selection of suture material, and the placing of the sutures with accurate coaptation of the incised edges with a minimum of tension.

The day has passed for the injection of paraffin, insertion of ivory, celluloid or other foreign materials, for the partial restoration of a lost part. The constant irritation of these foreign bodies may cause sloughing of the normal tissues, or may lead to cancer. The injection of paraffin is the sheet anchor of the "quack" facial specialist.

An important factor of plastic surgery is the realization of surgical limitation. It is better to do a series of plastic operations, giving nature time to do her part between each procedure, than to try to accomplish too much at one operation. The rebuilding of human tissues requires patience, painstaking care and attention to detail.

REPORT OF CASES

The following six case reports have been of particular interest because of the diversity of lesion and application of some of the principles mentioned above.

* * *

Case 1.—Male, aged eight years. When this patient was four years old he received a third-degree burn, caused by his father's cigarette igniting a bucket of gasoline. The healing of the burned areas about the ears, cheeks, lips and neck was rapidly followed by keloid formation, which enlarged to such an extent that the child's appearance was most unsightly. The keloid formation was difficult to combat. Prior to and following surgery, x-ray treatments proved inadequate and the use of radium was substituted with adequate success. (See Figs. 1 and 2.)

* * *

Case 2.—Female, aged sixteen years. This patient is one of twin girls who, the mother states, were so identical that she had difficulty in differentiating between them before infection caused disfigurement of one. At the age of twelve, a nasal operation followed by infection destroyed a portion of the septum, and this loss of cartilage produced a deep notch in the bridge, thereby causing a shortening and widening of the nose, and an elevated and narrowed upper lip. She was now quite unlike her twin sister, her once beautiful profile being destroyed, and causing her to develop an inferiority complex. The sisters, who dress identically and are inseparable, are motion picture actresses and naturally such a deformity became a travesty. Although artists covered her sunken nasal bridge with wax and make-up for screen work, the defect was still recorded by the camera. (See Fig. 3.)

A reconstructive rhinoplasty was a very delicate procedure, for she asked to be made to look exactly like her twin, as she did before the loss of the nasal septum. The sister's nose was used for a model and guide. Face masks, photographs and models of both girls were made for study and accurate measurements were taken. Two cast metal appliances were constructed. A splint was cast in silver from an impression taken from the carefully sculptured nose, of the desired anatomical shape for the purpose of moulding the tissues during postoperative regeneration of the tissues. A cast metal model was used for exact duplication in cartilage to fill the defect. Two sections of cartilage were removed from the region of the eighth and ninth ribs. One piece was carefully carved similar to the metal model, and the other piece was implanted in the adipose tissue under the skin of the abdomen for future use, if necessary. The results of this reconstructive rhinoplasty and the remodeling of the upper lip were highly satisfactory. In this instance it has meant not only the eradication of a rapidly developing inferiority complex, but the continuation of her success on the screen. (See Fig. 4.)

* * *

Case 3.—Male, aged twenty-two years. Congenital unilateral cleft palate and cleft lip. There is a history of nine operations between the ages of two weeks and fourteen years. The result of these surgical procedures shows an unsightly profile, a very narrow and contracted upper lip, everted lower lip hypertrophied to



Fig. 3



Fig. 4

Fig. 3 (Case 2).—Identical twins. Note the nose of the lower twin; how it is shortened, depressed and notched. Also drawn facial expression.

Fig. 4 (Case 2). Identical twins. Note the profile and improvement of facial expression. Nose reconstruction by transplantation of cartilage from rib and followed by anatomic moulding.

three times its normal size, a large cleft in hard palate, a soft palate wide open and a very short, flat, broad nose. At the previous operations, the surgeon failed to close the clefts in both hard and soft palates, and to reconstruct and remodel the nose. He also excised the premaxillary bones. (See Figs. 5 and 6.)

This patient has suffered all of his life, both functionally and socially, from his bad appearance and his speech impediment. He developed a feeling of being unwelcome in school or in the business and social worlds. The rebuilding of his face and mouth has required many operations, consisting of:

1. Lengthening of upper lip.
2. Reduction of lower lip.
3. Narrowing of nose and reshaping of nares.
4. Closure of cleft in hard palate.
5. Closure of cleft in soft palate by "push back" operation.
6. Construction of special dental appliance.
7. Lengthening of nose and elevation of nasal tip by transplantation of cartilage.
8. Lengthening of columella by utilizing the tubed graft secured from the chest.
9. Widening of upper lip by utilizing the tubed graft secured from the chest.
10. Reconstruction of philtrum and cupid's bow.

This long series of plastic work would have been unnecessary, if the patient had had skillful reconstructive surgery in infancy. He would have been spared, also, an unhappy life of impaired function and mental anguish. (See Figs. 7 and 8.)

* * *

Case 4.—Female, aged twenty-five years. The nose of this young woman has been injured at birth, due to misuse of forceps. Being in public life as a school teacher, she had developed an inferiority complex. She stated that from early childhood she had been acutely conscious of her deformity, and had suffered mentally because of her appearance. Not only had the acquired nasal disfigurement impaired her personal appearance, but the constricted nares prevented normal breathing. The accompanying photograph, illustrated in Fig. 9, shows the nose to be elongated, with a broad, flat, depressed tip, an excessive "hump" and abnormally shaped nostrils.



Fig. 5



Fig. 6



Fig. 7



Fig. 8

Fig. 5 (Case 3).—Note unsightly profile due to congenital cleft palate, cleft lip and bad surgery. Note short, flat, broad nose, short columella, broad nostrils, retracted upper lip, protruded and hypertrophied lower lip.

Fig. 6 (Case 3).—Note cleft palate, wide nostrils and flattened nose. The premaxillary bones had been excised when a baby.

Fig. 7 (Case 3).—Note the closure of the cleft of soft and hard palates by the Dorrance "push back" operations.

Fig. 8 (Case 3).—Surgery completed. Showing results accomplished from numerous reconstructive operations. Compare profile with Fig. 5.



Fig. 9



Fig. 10

Fig. 9 (Case 4).—An acquired nasal deformity by misuse of forceps at birth. Note the excessive size, prominent "hump" and length.

Fig. 10 (Case 4).—Result obtained from corrective rhinoplasty. Operation "in toto" was done.

The surgery consisted of reducing the protruding nasal bones, shortening and lowering the septum, narrowing and pointing the tip, elevating the columella, reshaping the nostrils and reducing the nasal processes of the superior maxillary bones. The photograph, illustrated in Fig. 10, was taken three months following surgery, and attention is called not only to the improvement in the nasal form but to the facial contour, with a widened upper lip and pleasing expression. This young lady has developed an entirely different mental attitude, is not depressed, and her inferiority complex has vanished due to the restoration of normal breathing and improvement in her personal appearance.

* * *

Case 5.—Female. This patient gave a history of having a lower right third molar removed with prompt healing of the socket, without pain. Six months later a fistula appeared in the lower right face. She consulted several doctors and dentists, and numerous x-ray films have been taken. When examined, her only complaint was of a copiously discharging fistula on her right face which required frequent change of dressings.

Examination showed that this patient practiced efficient oral hygiene. No intra-oral lesions could be found. Bacteriological examination of smears, from both the external opening and the inside of the fistulous tract, revealed numerous pus cells, gram-positive and gram-negative bacilli, fusiform bacilli and spirilla. These findings were indicative of Vincent's infection. A small blunt probe was inserted into the fistulous tract, which was found to extend to the third molar socket.

Treatment consisted of opening of the third molar area by incising the apparently healthy mucoperiosteum covering the area. The fistulous tract was treated by irrigations. Two intravenous neosalvarsan injections were given. After three days no discharge



Fig. 11



Fig. 12



Fig. 13

Fig. 11 (Case 6).—Illustrating the tubed pedicle graft which was used to reconstruct the left face.

Fig. 12 (Case 6).—Illustrating the tubed graft in position three days after operation. The buttons were used to prevent injury to skin from sutures.

Fig. 13 (Case 6).—Surgery completed. The tubed graft was spread out and inserted through a one-inch incision beneath the left jaw, which restored normal facial contour of the left cheek, eyelid, nasal ala and upper lip.

was apparent, and in ten days the tissues were apparently healed. This long continued infection had caused an adherence of the skin to the mandible at the fistulous opening, destroying the normal surface contour and resulting in an unsightly scar.

The adherent scar was separated from the mandible, the surrounding subcutaneous tissues were approximated, and the normal surface contour was restored.

* * *

Case 6.—Female, aged twenty-two years. At the age of ten this patient was struck with a baseball on the left side of the face. The impact fractured the anterior wall of the antrum, the malar bone and the infra-orbital margin of the superior maxillary bone. The x-ray revealed almost complete obliteration of the superior maxillary sinus. Examination revealed that the left cheek and the tissues covering the infra-orbital margin were depressed. There was an ectropion of the lower left eyelid, and the left ala was widened and distorted, with the left angle of the mouth drooping and pulled to the left side. The natural contour was destroyed, there being a concave surface instead of the normal convex outline. Measurements revealed that the concavity of the left side of the face was three-quarters of an inch beneath the normal contour line, as compared with that of the right. The thickness of the cheek at the deepest portion of the concavity was an eighth of an inch, and gave the impression to the palpating fingers that only skin and mucous membrane were present. (See Fig. 11.)

A tubed flap containing considerable adipose tissue was prepared from the skin on the left side of the abdomen and was transferred in four steps to the face. An incision, one and one-quarter inches long, was made parallel to the lower border of the left mandible. The skin was carefully loosened from the underlying tissues at the angle of the mouth, beneath the ala, and into the lower eyelid and extending one-half inch anterior to the left ear. The lower end of the tube was opened and the tissue modeled to a form constructed prior to operation. Equidistant sutures were placed in the margin of the flap. The graft was placed in position and the sutures were tied over buttons. Three weeks later the tube was severed, the lower portion of the graft was shaped to the proper contour and the skin incision closed. (See Fig. 12.)

Illustration 13 shows the restoration of normal facial contour and left ala. The lower eyelid and lip are normal and there is restoration of expression.

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DISCUSSION

William S. Kiskadden, M. D. (1930 Wilshire Boulevard, Los Angeles). — The author has covered the general field of reconstruction surgery briefly, but thoroughly; and with one or two minor exceptions, I am in accord with his ideas.

It has not been my experience that either total or partial absence of the eyelids is easy satisfactorily to correct. Moreover, my experience with the removal of tattoo marks, skin discolorations, or chemical staining has left a rather deep impression of how difficult, and sometimes disappointing, is the treatment of these conditions.

I am glad that Doctor Smith mentioned the deformity and malformation that may result in noses following slight or forgotten injuries in childhood. I feel that these should be treated conservatively when discovered, and if the distortion is not too severe or disfiguring it is wiser to postpone surgery till the age of sixteen, when growth of the nose has usually ceased. Treatment before this time may give a good immediate postoperative result, but subsequent growth often causes even worse distortion than existed preoperatively.

The treatment of keloid following burns is one of the many ever recurring problems that the plastic surgeon faces. X-ray, of course, in small, divided weekly doses, is of distinct value. However, the implantation of skin in the form of a graft, either split skin, whole thickness or pedicle in type, will often result in amazing smoothing, thinning, and softening of the surrounding thick keloid. The rationale of early grafting of all burns or denuded surfaces as a preventive against keloid formation and subsequent contraction, is obvious.

Francis L. Anton, M. D. (702 Wilshire Medical Building, Los Angeles). — The plastic surgeon must combine science with art to an eminent degree. He must add to these qualifications no small amount of moral courage, because his success or failure is a constant walking advertisement of his work. Good surgical judgment and a great amount of patience are also required. Many of these reconstructive undertakings require months and sometimes years for their ultimate accomplishment, and oftentimes can only be done a step or two at a time.

Great, indeed, however, is the satisfaction of being able to convert a repulsive monstrosity—for instance, a cleft lip or palate case—into an acceptable member of the human society; and it is well worth the time and patience devoted to it. Disabling or disfiguring scars, as well as other and greater deformities, whether congenital or acquired, frequently produce an inferiority complex in the possessor of such defects which makes him very unhappy and reduces his usefulness.

Since well-trained scientific men have become interested in this work and have taken it out of the hands of charlatan beauty specialists, great progress and healthy improvement in the work has developed.

The unsatisfactory and often dangerous injection of paraffin has been replaced by tissue transplantation to fill out defects and sunken areas. Bone and cartilage transplantations are placed where a more solid support is needed. The transplantation of tendons and nerves often produces most wonderful effects in infantile paralysis, and in cases of industrial or automobile accidents.

George Warren Pierce, M. D. (490 Post Street, San Francisco).—It is true that there is a lack of knowledge concerning the scope and capacity of reconstruction surgery, not only among the laity, but also to a considerable extent throughout the medical profession. However, I wish that Doctor Smith had given us for this meeting less of a catalogue of the possibilities of this specialty and more of discussion of the refined technique that is required in dealing with its varied problems.

I will frankly criticize one of Doctor Smith's statements—that "acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected." To me, reconstruction of an eyelid for total absence is most exacting and difficult, and if Doctor Smith will tell me how it can be easily corrected I will be most grateful.

Of special interest was the case of correction of the deformities following the badly operated cleft lip and palate. In the light of our present knowledge deformities such as these are inexcusable. The surgeon who undertakes to "do" a cleft lip and palate should be certain that he can offer to the patient a more than fair chance to receive a lip which will offer an almost normal appearance, a reconstituted musculature and function, and a nose whose columella is in midline with alae and nostrils approximately similar. He should be confident that he can give the patient a long palate with mobile velum which will permit speech free from the characteristic cleft palate enunciation.

The majority of surgeons who do a large number of cleft palate operations agree that the use of wires and plates, after the technique of Brophy, is detrimental to the best results, and that their use arrests development of the superior maxillae and is apt to destroy the tooth buds. Far better average results are obtained by reconstructing the lip and nose, and allowing the constant elastic action of the reconstituted orbicularis oris to gradually mold the protruding alveolar process into normal position, which it surprisingly does. The secret of primary healing of the palate

and velum is absence of tension on the suture lines. This can only be obtained by free dissection around the posterior end of the alveolar process. If this freeing of the tissues is efficient, no stay sutures or wires are necessary.

❦

Doctor Smith (Closing).—I wish to thank Doctor Pierce for his taking exception to my statement, *i. e.*, "Acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected." Possibly the word "easily" should have been omitted, because all plastic operations of any magnitude upon the face demand painstaking and exacting surgical technique, and also the application of mechanical principles. The results obtained, both functional and cosmetic, from reconstructive operations on eyelids upon patients coming under my observation have been most encouraging and gratifying. In some of these cases the eyelid was not only reconstructed, but eyelashes were restored. Other operations which are difficult are the restoring of an ear, nasal ala, and lip. Restoration of function and cosmetic appearance are paramount. As time passes, and as I become more and more familiar with the almost unlimited intricacies of reconstructive plastic and oral surgery, I am convinced that one not thoroughly trained in this highly specialized branch of general surgery should not attempt it. It is seldom that two plastic or oral cases are alike, therefore each case demands individual study and preoperative planning in order to determine the proper method of reconstruction. The case should be studied from every standpoint. Efficient results are based upon sound surgical and mechanical judgment, and the determining of just what should be done. Surgery of this type cannot be done in a hurry. A single operation of a complicated case may require several hours, due to the great detail and difficulties encountered. In many cases numerous operations are necessary to accomplish a good functional and cosmetic result.

SURGICAL RELAXATION*

By John Robert Burrows, M. D.
San Francisco

Discussion *by Caroline B. Palmer, M. D., San Francisco; Mary E. Botsford, M.D., San Francisco; W. F. Chalmers-Francis, M.D., Los Angeles.*

SURGICAL relaxation is a problem that confronts the anesthetist each time an anesthetic is administered. Considering the various types and conditions of patients that are presented, can full relaxation always be given, maintaining, at the same time, the safety of the patient and acceding to the demands of the surgeon? Let us review, briefly, the more common methods and agents of anesthesia, with consideration of their safety and efficiency.

SPINAL ANESTHESIA

Spinal anesthesia, of all anesthetic agents, in that part of the body affected, gives the most complete relaxation. In recent years its safety has been increased by improved technique, the use of less toxic agents, and also of ephedrin and CO_2 and O. Its effect, however, is limited in duration. This can be controlled to a certain extent by the amount of the agent administered and, more recently, by the combination with novocain (the most commonly used agent) of such drugs as pantocain and nupercain, which have a longer duration of action than novocain. Pantocain and nupercain are more toxic than novocain, though that, to a degree, is made up for by the smallness of the dose required. Nevertheless, while the safety of spinal anesthesia has been decidedly increased, there still seems much to be desired. Alarming drops of blood pressure continue to occur; likewise, marked circulatory and respiratory depressions. The debate as to its safety still continues, and the great majority decline to use spinal anesthesia for operations above the diaphragm. Mortality has been placed anywhere from one in three hundred to the claim of no mortality whatever. It certainly has its place in anesthesia, especially when used in selected cases, though the popularity of a few years back would appear to be decreasing. There seems to be very little difference in postoperative pulmonary complications between this anesthetic agent and others. The height of the anesthesia apparently is not as controllable as one would be led to believe, similar doses and similar amounts of fluid not infrequently giving quite different results.

Other forms of regional anesthesia are decidedly safer than spinal, though occasionally a patient may have an idiosyncrasy against the agent used; and it may show a lack of efficiency in itself and so require the addition of some inhalation anesthetic.

CHLOROFORM AND ETHER

Chloroform gives an excellent degree of relaxation; but its high toxicity and its danger to the patient, both immediate and remote, have rendered its use unjustified.

Ether ordinarily gives a good relaxation; and though its toxicity is fairly high, it has a wide margin of safety. It is true that it tends to be somewhat irritable to pulmonary tissue, and is contraindicated in pulmonary affections. Likewise, it is not suitable in cases with kidney complications. Taking it altogether, the writer believes that ether, properly given, has a high degree of safety, and it would seem that postoperative complications, following ether, are due to the location of the operation rather than to the anesthetic agent.

NITROUS OXID AND ETHYLENE

Nitrous oxid with oxygen is a very safe anesthetic when properly given. It is rapidly absorbed and rapidly eliminated. Its toxicity is apparently nil, and muscle tone is not lost. In those cases requiring a full relaxation, it would be necessary to use, in addition to nitrous oxid and oxygen, either a local infiltration or the addition of ether, and proper premedication is absolutely necessary in any case for a smooth anesthesia with this agent. McKesson, by what he terms a secondary saturation, seems to be able in at least the large majority of his cases to obtain relaxation suitable for any case with nitrous oxid and oxygen alone.

* From Stanford University Hospital.

Read before the Anesthesiology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

While, in his hands, this procedure seems successful, both as to relaxation and safety, it has not been found so in the hands of others, and the writer cannot help but feel that it is not justifiable.

The same that has been said of nitrous oxid may be said of *ethylene*, except that ethylene gives somewhat more relaxation, and a higher percentage of oxygen can be used.

INTRATRACHEAL ANESTHESIA

The *intratracheal* administration of anesthetics gives a very satisfactory relaxation, though it requires a deep etherization to permit the passage of the tube into the trachea, or, as used by some, a topical application of a strong solution of cocain; also, there is some danger of injury to the vocal chords or the pulmonary tissue.

ETHYL CHLORID

Ethyl chlorid is usually used for very short operations and will, in such cases, give a fair relaxation, though sometimes masseteric spasm will interfere. Its safety probably lies somewhere between ether and chloroform.

AVERTIN

Avertin, used as a basal anesthetic, and in the dose calculated by bodyweight, seems to be a fairly safe procedure. It should never be used as an absolute anesthetic. With the addition of nitrous oxid and oxygen, it gives a fairly good relaxation, and permits at the same time a larger percentage of oxygen with nitrous oxid, or a lesser amount of ether. Used with a local anesthetic, its action is not always so satisfactory. There seems to be quite a variation in analgesia, as well as in relaxation, in patients apparently requiring similar doses. As it may be given in the room, and the patient be asleep before being brought to the operating room, it is particularly useful in apprehensive and very nervous patients.

PREANESTHESIA MEDICATION

As premedication before anesthesia, it has been found that the *barbitals*, with their hypnotic, sedative and antispasmodic action, are extremely useful, combined with morphin or pantopon. *Sodium amytal* not infrequently will give a certain degree of excitement, which seems to interfere with a smooth induction of anesthesia. Any one of the barbitals, given in a large dose, is very apt to interfere with the successful maintenance of anesthesia by reason of a depression of respiration. The intravenous use of the barbitals we, at Stanford University Hospital, agreeing with the Council of the American Medical Association, feel is not justified, believing that equally good results can be obtained in the anesthetic field in the use of such drugs by mouth.

With *scopolamin* we have had too many cases of depressed respiration to make us feel justified in its routine use.

PROCEDURES PRIOR TO OPERATION

Now, let us speak of such things, prior to operation, as will help the anesthetist in the proper administration of the anesthetic, and which will aid in obtaining the proper degree of relaxation required. First, proper preparation; secondly, a restful night, usually to be obtained by a small dose of some sedative; and, lastly, a proper dose of some barbital administered previous to operation, and followed by morphin or pantopon. After administration of the barbital, the patient should be kept as quiet as possible, and from then on with as little excitement as is possible. The effect of premedication has often been destroyed by the visits and conversations of well-meaning friends. The removal of the patient to the operating suite should also be done as quietly as possible, and the patient placed in a suitable position on the table so that there is no strain on any of the muscles. This matter of unstrained position is exceedingly important. After then having been moved quietly to the operating room, and a few reassuring words spoken to the patient, the anesthesia should be started in as unhurried a manner as possible. Many anesthesias have been spoiled by someone saying "to hurry." The usual result is a rough induction, ending in overdosing the patient. The administration of any inhalation anesthetic requires at least ten minutes (some say fifteen) to obtain the state of surgical anesthesia. Another thing; an unobstructed airway is absolutely essential, and most important in the maintenance of a smooth anesthesia.

FACTORS ANTAGONISTIC TO SMOOTH ANESTHESIA

Those things that will work against the anesthetist in obtaining a smooth anesthesia will be the nature of the patient, his habits and mode of life, improper preparation, the giving of too much or too little premedication, a hurriedly given anesthetic, or an incision made too soon, and, during the operation, a strained position (which is not always avoidable), but, perhaps most important of all, a partially obstructed airway.

THE RESPONSIBILITIES OF THE ANESTHETIST

After the anesthetic is begun, the anesthetist's entire attention should be concentrated upon the patient; but in order to give an intelligent anesthetic, the writer feels it to be necessary that the anesthetist have some knowledge of what the surgeon is doing, for in a great number of operations, as we all know, it is not necessary to keep the anesthesia on the same level. As, for instance, in a gastro-enterostomy, when the bowel and stomach are in a position to be sutured and the retraction has been lessened, anesthesia may be lightened considerably, deepening it again a little before the surgeon is ready to replace the organs in the peritoneal cavity. Should the respirations tend to become shallow, or jerky, or straining in character, the addition of carbon dioxid, either by rebreathing, or directly with oxygen, will tend, by causing the respiration to become deep and regular, and possibly by some antispasmodic action of the carbon dioxid, to smooth out a rough anesthesia into a quiet one, and so help to main-

tain surgical anesthesia more easily and quietly. The amount of relaxation obtained will depend upon the amount of anesthetic agent given and its potency.

ON THE DEGREE OF RELAXATION REQUIRED

The degree of relaxation required in the average case will depend a great deal upon the site of operation and the nature of the work to be done. Intra-abdominal work, especially about the gall-bladder and stomach, and deep pelvic operations, require the deepest anesthesia. Surgeon and anesthetist, both, have first in mind the safety of the patient; next, the most efficient way, on the part of the surgeon, in which the work can be performed, his objective being to correct some pathological condition. The anesthetist, on his part, wishes to administer such an anesthetic as will enable the surgeon to perform his work as easily and efficiently as possible. Of course, if this can be done in as agreeable a manner as possible to the patient, so much the better; but safety and efficiency must come first. The anesthetist's procedure will depend upon the operation to be performed, and upon the needs or demands of the surgeon. Every surgeon differs in his technique, and in the degree of relaxation he demands; from those who have accommodated their technique to the limitations of nitrous oxid and local infiltration, on through to those who will demand the very deepest of anesthesia, especially in any abdominal work.

The effect upon the patient will depend upon the potency of the anesthetic agent, which, generally speaking, will vary directly with its toxicity, the length of administration, and upon the rapidity with which it is eliminated. The anesthetic agent and method of administration must be chosen according to the condition of the patient, as well as the needs of the surgeon. The advisability of great muscular relaxation will likewise depend upon the condition of the patient and the limitations of the anesthetic selected.

SPECIAL CASES

It occasionally happens that a patient is found who, although proper preoperative preparation has been given, will not yield the desired relaxation, even though carried to the deepest depths of anesthesia that safety permits. The writer has, on more than one such occasion, been forced to refuse to carry the anesthesia deeper because the patient was then verging upon the fourth stage, while the surgeon was still not satisfied with the relaxation obtained. In some such resistant cases, where a large amount of ether had previously been given, the writer has been asked to add a little chloroform. This he did on two occasions, the dose not exceeding ten drops, slowly given, but with almost fatal results.

Complete surgical relaxation is *not* possible in all cases, without danger to the patient. For instance, when the writer first witnessed the operation for the relief of hypertrophic pyloric stenosis, it was done by gastro-enterostomy, which required a deep anesthesia and was a comparatively long procedure that required deep relaxation. The mortality following this procedure was high. When Weeks introduced in San Francisco the Fredet-Ramstedt operation, the procedure was short, and he required the lightest possible anesthesia, with the result that his mortality was very low.

IMPORTANT TO RECOGNIZE THE LIMITATIONS OF AN ANESTHETIC

The question of recognizing the limitations of an anesthetic agent cannot be too strongly stressed. It is just here that the coöperation of the surgeon is particularly important. Let us take, for example, after consultation, a patient has been declared suitable only for either nitrous oxid and oxygen or ethylene, combined with local infiltration. After the operation is under way the surgeon, for some reason or other, demands the addition of ether to gain further relaxation, with the result that the patient may be lost.

An associate of the writer was once called in consultation by a surgeon as to whether an anesthetic could be given to a certain patient whom, the internists had declared, would die without surgical interference and who, on the other hand, would not be able to take an anesthetic. The anesthetist expressed the opinion that with the use of nitrous oxid and oxygen there was a fighting chance, provided the surgeon would coöperate with her as to the limitations of the anesthetic agent, and agree to stop his manipulation if the patient became roused, and wait until the patient was again under control. Under these conditions the operation was performed and the patient left the hospital in good condition, dying some years later from a complaint entirely foreign to that for which he had been operated upon.

NEED FOR CLOSE COÖPERATION BETWEEN SURGEON AND ANESTHETIST

There is no intention in this paper to presume to dictate to the surgeon as to how his work should be done, nor to criticize his procedure, but only an earnest desire to show the necessity and benefit of closer coöperation between surgeon and anesthetist. Above all things, we do not want to work at cross-purposes with him. If something should go wrong with the anesthesia, or the patient does not reach the desired stage of surgical anesthesia as quickly as usual, it would certainly be much more beneficial to all concerned that all manipulation cease until the difficulty is straightened out, or the desired degree of relaxation is attained. Otherwise, one is not only more than apt to cause interference in the operating procedure but, also, to overdose the patient. The anesthetist, it is true, should try to anticipate the surgeon's needs; but he cannot always foresee the next move, and it would indeed be helpful if some unusual manipulation is contemplated, which will require deeper anesthesia, to be warned of it.

The wish of all of us is to administer an anesthetic that is safe to the patient and efficient

for the surgeon's needs, and, if possible, agreeable to the patient; but safety and efficiency must come first.

IN CONCLUSION

1. Complete surgical relaxation is not safe, necessary, or possible, in every case.

2. The anesthetic agent must be chosen according to the condition of the patient.

3. Recognizing the limitations of the anesthetic agent is most important.

4. Coöperation between surgeon and anesthetist is particularly essential.

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DISCUSSION

Caroline B. Palmer, M. D. (2904 California Street, San Francisco).—I would like to stress one of the points brought out in this paper because of its great importance.

The failure to take into consideration the limitations of certain anesthetics leads to poor anesthesia and is often fraught with danger.

Most physicians and surgeons know that nitrous oxid and oxygen alone can give but slight relaxation, and yet anesthetists are frequently asked to administer this anesthetic for operations requiring marked relaxation. Worse still, the request is sometimes made that no premedication be given. This necessarily spells failure, and commonly leads to the use of ether in cases where ether is contraindicated.

Mary E. Botsford, M. D. (807 Francisco Street, San Francisco). — Doctor Burrows' timely paper might aptly be named "The Dangers of Surgical Relaxation," and the answer to the question he asks as to the possibility of obtaining full relaxation safely in every case is emphatically no. Some research done at Johns Hopkins Medical School a few years ago by Gatch and Mann showed the cause of many anesthetic deaths to be the determination of blood to the valveless splanchnic area, producing cerebral anemia when the anesthetic is pushed to the deepest stage in order to obtain muscular relaxation. Probably much of the mortality of spinal anesthesia is due to this relaxation of intestinal muscle tone.

The need for preoperative medication is clearly shown: the combination of hypnotics and sedatives, such as the barbiturates, avertin and similar drugs, selected for the individual case, is of the greatest value in reducing the amount of the anesthetic agent necessary to produce sufficient relaxation for the operative procedure.

The necessity for the anesthetist to be aware of the stages of the operation, so that the depth of the anesthesia may be increased or lessened accordingly, is well emphasized and is a strong argument for the medical anesthetist.

The status of the anesthetist as "physician of the surgical team" is demonstrated, as is his value to the surgeon in relieving him of the necessity of "supervising" the administration of the anesthetic, since the individual reaction of the patient can be recognized only by the anesthetist.

Crile has proved the advantages of light anesthesia and the possibility of the performance of every surgical procedure by gentle manipulation, rather than by the method which he terms "insulting the peritoneum." The extremes of age, even such limits as five hours and ninety-six years, offer no bar to safe anesthesia, provided deep surgical relaxation be not required.

The conclusion drawn is that the true criterion of an anesthesia is not depth, but safety.

W. V. Chalmers-Francis, M. D. (1136 West Sixth Street, Los Angeles).—Surgical relaxation is an unknown quantity. In practice, to one surgeon the light stage of anesthesia is perfect for his technique, to another surgeon no stage less than the deepest, most risky narcosis is satisfactory to his special abilities.

Spinal anesthesia gives complete relaxation, comparable to that in death, following the passing of *rigor mortis*; it is safer than ten years ago, but the anesthetist differs from the surgeon, who bases his success on percentages of his results, while the anesthetist figures on the 10,000 to 100,000 valuation of his cases. Spinal anesthesia deaths are in the 1 to 100-1000 valuation; nitrous oxid and ether in the higher records, up to 1 in 70,000. We feel the relaxation of spinals is to be valued in "the safety of the patient," and we compare it with the safety of "balanced anesthesia" (the use of local with the general administration of gas inhalations), with gas-ether sequence, or ether alone, and find spinal wanting in comparison with their safety margin, even today. We talk "selected cases" and hesitate to support it as comparable to the use of other dangerous drugs we prescribe the dosages of; diagnose their reactions with the individual patients and treat these varying conditions every moment as they indicate to our judgment and skill.

Chloroform is the best inhalation anesthetic today, in so far as relaxation is obtainable, but it is disapproved of because of its marked toxicity and late effects. In competent hands it can and is used with a high degree of success, but the use is to be depreciated when compared with other inhalation anesthesia on the basis of "safety to the patient." However, in use as an adjunct to ether in small dosages it shows a higher margin of safety than spinal (Dr. A. H. Miller Fiske Fund Essay, R. I. Med. Jour., September 31) and aids in relaxation with marked value.

Ether in the hands of most of us is the safest relaxation producer we have after one hundred years of usage. In expert hands it is practically free of serious complications, and postoperative vomiting and lung changes are avoidable to a large extent. Incidentally, if half the effort devoted to studying spinals and gas anesthesia were expended to train men to the proper application of ether, very few would use other inhalations.

In my opinion no good relaxation is obtained with "gas" anesthesia, be it nitrous or ethylene gas alone. To obtain relaxation one must use "combined anesthesia," that is, to use barbiturates, opiates, scopolamin, etc., followed up with gas inhalation anesthesia to produce relaxation. Here is the best work done, from the patient's point of view; an important matter. Add to this the technique of apnea production, the filter method, with rebreathing, many will be won to their daily use and teamwork.

The potency of drugs varies with the metabolic rate: the metabolic rate is varied by many conditions, *e. g.*, age, fever, thyroid activity, fear, etc. The potency of N_2O varies with that of ether and chloroform. To relax a patient we must work within the area of potency of the drug, which varies as fear, etc., raise the metabolic rate and lower the potency; this must be considered and diagnosed, and controlled by premedication with barbiturates, morphin, etc. All these considerations demand consultation and understanding by both the surgeon and anesthetist; for as much more as the surgeon knows his surgery, so much less does he know his anesthesia, the two fields, coöperating in the operating room, separate widely in their fields of study outside their close contact at the table, and few can or do devote their reading and study to both investigations.

Doctor Burrows has covered the ground so well that the value stressed is forever before the profession for impressive guidance.

COMMON DERMATOSES—SOME UNUSUAL MANIFESTATIONS*

By Nelson Paul Anderson, M. D.
and
Samuel Ayres, Jr., M. D.
Los Angeles

Discussion *by John M. Graves, M. D., San Francisco; Ernest D. Chipman, M. D., San Francisco; John L. Fanning, M. D., Sacramento.*

THE purpose of this paper is to record and present some of the less common conditions which occasionally occur in conjunction with the more common skin diseases.

VERRUCA VULGARIS A FREQUENTLY SEEN DERMATOLOGICAL CONDITION

Verruca vulgaris is one of the most common dermatological conditions, particularly in children of school age. Involvement of the mucous membranes by the virus causing common warts is distinctly uncommon. We have seen one such case recently where the entire mucous membranes of the lips and even the gums were involved. There were a tremendous number of pea-sized and smaller papillomatous lesions present (Fig. 1). The infection in these cases is probably transferred from hands to mouth, as they are usually seen in children who have warts on the hands or about the finger nails, and who are in the habit of biting their nails. In this connection it is interesting to speculate concerning the origin of laryngeal papillomas. We know from experimental work that the virus producing papillomas of the larynx is very similar to if not identical with that causing the common wart. As far as we know, no common wart has ever taken on malignant characteristics, and yet papillomas of the larynx are definitely a precancerous condition.

PITYRIASIS ROSEA

We are all acquainted with the cutaneous manifestations of pityriasis rosea. It is rather uncommon, however, for this condition to involve the face to any marked degree. Such an instance of facial involvement is well shown in Figure 2. Very rarely, the mother spot may appear on the shaft of the penis. Gigantic herald spots have been reported. Hemorrhagic forms of pityriasis rosea occasionally occur.

PHYTID ERUPTIONS OF THE HAND

The so-called "phytid" eruptions of the hands as a complication or accompaniment of fungus infections of the feet, are familiar to us all. Lichenoid trichophytid eruptions of the trunk occur in connection with ringworm of the scalp, particularly infections of a kerionic nature, or after epilation of the scalp hair by x-ray.

FUNGUS INFECTIONS OF THE FEET

Certain cases of fungus infection of the feet are accompanied by pityriasiform eruptions of the trunk. At times, these eruptions are indistinguishable from pityriasis rosea, and the differentiation can only be made after a period of observation. We might mention also a case where the external ear was the seat of an actual infection with the epidermophyton fungus, the organism being isolated from the scales.

RINGWORM OF THE SCALP

Ringworm of the scalp is, for all practical purposes, limited to children under the age of puberty. In the past few years, however, we have seen three cases of ringworm of the scalp in adults. In each of these cases the diagnosis was confirmed microscopically by the finding of spores in the infected hairs. In one of the cases the nails of the fingers were also involved, and the infection on the scalp had given rise to an atrophic scarring alopecia. No determination of the pathogenic fungus was made, although cultures were sent to two competent mycologists. The organism was definitely not that of favus.

TINEA VERSICOLOR

Tinea versicolor is a relatively common skin condition which we ordinarily pass by without comment. However, when the lesions are found on the face, as in a case recently seen, they are apt to be mistaken for chloasma, and it is uncommon to find this condition on the forearm and wrist, as in a recent case.

NEUROTIC EXCORIATIONS

Neurotic excoriations are generally seen on areas of the body easily reached by the hands, more particularly the face. We have encountered one case in which, in addition to lesions on the face and nose, there were large punched-out ulcerations of the gums and buccal mucosa. This occurred in an edentulous person.

PSORIASIS

In psoriasis the palms and soles are rarely affected. Most cases so diagnosed are proved eventually to be due to syphilis, occupational irritants, or eczema. It is possible for psoriasis to involve the palms and soles, as shown in Figures 3 and 4. The lesions are dry, erythematous, scaly patches, and occasionally have a verrucous aspect. Psoriatic patches on the mucous membranes do occur. In one case which we have seen, the patch simulated leukoplakia, but the intensity of the condition fluctuated with the severity of the psoriasis.

It would probably be best to avoid entirely such a controversial subject as pustular psoriasis. We had a case two years ago of a severe pustular eruption which occurred in a woman who had had a definite psoriasis for about fifteen years. The pustular aspect of the condition began during pregnancy and cleared following delivery. Whether this should be regarded as an impetigo herpetiformis, or a pustular psoriasis, is perhaps an open question.

LICHEN PLANUS

Lichen planus rarely involves the palms, and yet in a case recently seen there were numerous

* Read before the Dermatology and Syphilology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.



Fig. 1.—Verruca vulgaris involving mucous membranes of the mouth.



Fig. 2.—Pityriasis rosea with extensive involvement of face.



Fig. 3.—Psoriasis involving palms—an unusual location. (Same patient as Fig. 4.)

small papules present on the palms. Nail changes are certainly not typical of lichen planus, but we recently saw a case where there was scaling of the cuticle with a purplish discoloration of the nail. Both of the cases were accompanied by a marked generalized and acute eruption.

LUPUS ERYTHEMATOSUS

The common types of lupus erythematosus are too well known to require comment. There is, however, a telangiectatic type which is rarely diagnosed. Such an instance was presented in a recent case.

PEMPHIGUS

Pemphigus does occasionally occur in an isolated area, particularly on mucous membranes before becoming generalized. But a distinctly rare condition is presented by cases of pemphigus of the conjunctiva. This is also known as essential shrinkage of the conjunctiva.

SYPHILIS

Syphilis is, of course, the great imitator, and it is not in the province of this paper to more than merely mention some of its eccentricities. The occurrence of psoriasiform syphilis or zosteriform syphilis and its occasional tendency to mimic lupus erythematosus (Fig. 5) show clearly its ability to imitate many common skin conditions.

HERPES ZOSTER

The ordinary case of herpes zoster is familiar to all, but rarely this condition involves the mucous membranes of the mouth; and in one case, seen two years ago, there were lesions on the hard palate and an associated seventh nerve palsy.

Angiomas are not rare in children, and their location about the genitals is quite common. Yet we believe that involvement of the glans and shaft of the penis by such a nevoid process is rather unique.

CONTACT DERMATITIS

One could write a book on the unusual manifestations of contact dermatitis. The so-called "toilet seat" dermatitis and "match box" dermatitis, are not uncommonly seen. The face and hands, however, are the areas usually involved. It is interesting to cite a case in which, after a prolonged search, it was definitely shown that the eruption on the face was due to resin, with which the patient came in contact by two separate ways: first, through the use of resin on her violin bow,



Fig. 4.—Psoriasis involving the soles—an unusual location. (Same patient as Fig. 3.)



Fig. 5.—Syphilis resembling lupus erythematosus.



Fig. 6.—Nickel dermatitis from white gold wrist watch and positive patch test to a nickel chain on the right forearm.

and secondly through the use of resin on the dance floor, the patient being both a toe dancer and a violinist. A case of nickel dermatitis due to a wrist watch is shown in Fig. 6, with a positive patch test to a nickel coin showing on the right forearm.

ACNE

Acne, at the age of puberty, might be termed a physiologic process due to its frequency; yet infantile acne, although rare, does occur. Acne in middle age is also uncommon, excepting, of course, acne rosacea; yet we recently met with a case of acne which appeared following an exfoliating dermatitis due to arsenic. This patient had not previously been subject to acne.

SCABIES

Scabies is certainly one of our most common dermatological conditions which, however, at times may manifest itself in uncommon ways. All dermatologists are acquainted with those cases which present only an occasional burrow or papulo-vesicle, and whose chief manifestation is one that is generally and mistakenly called urticaria or hives. The persistent nodules which occur as infrequent sequelae to scabies are often overlooked or mistakenly diagnosed. These persistent nodules of scabies are probably what is termed, by the French, post scabetic keloids, which they resemble both in appearance and resistance to treatment. We have one case of arsenical dermatitis, which occurred in a luetic patient who developed scabies while receiving neoarsphenamin. The arsenical dermatitis apparently started following the use of sulphur ointment.

IN CONCLUSION

We have attempted to enumerate and briefly discuss some of the rarer types of eruptions which occur either independently of, or in conjunction with, some of the more common skin diseases.

2007 Wilshire Boulevard.

DISCUSSION

John M. Graves, M. D. (909 Hyde Street, San Francisco). — There are two conditions mentioned by Doctor Anderson that I believe may be emphasized.

The treatment of tinea capitis was very unsatisfactory until the advent of the x-ray. The application of this method, of course, cures the vast majority of cases. Thallium acetate has been used for depilation, but it is too toxic for general use. As depilation is not always complete, this method too often fails to cure.

In recent years, local treatment has been used on the Pacific Coast with very satisfactory results. Doctor Kingery of Portland was the first, I believe, to revive this simple method. He recommends a combination of oil of cinnamon and thymol. Most patients are well within a period of from three or four months. This has been tried in other parts of the country with unsatisfactory results; but there is no apparent reason for this discrepancy.

One must distinguish carefully between uncured scabies and postscabetic nodules. The latter are possibly due to trauma induced by scratching. Fortunately, this is not a common aftermath of scabies. Measures to control the pruritus would seem to be indicated. If this be successful, the results are usually satisfactory.

Ernest D. Chipman, M. D. (2000 Van Ness Avenue, San Francisco). — The paper under discussion is of value for what it suggests, as well as for what it states.

The concomitance of lesions of different types, some of which may be merely coincidental, and some simply consecutive, gives to the analysis of eruptive elements a constant source of interest.

The fact that an individual has any certain dermatosis does not, of course, signify that immunity to other skin affections is thereby bestowed; if anything, the reverse is the more probable. And while the coincidence of non-related lesions often is noted, there frequently appear lesions which are definitely sequential; for example, the impetiginization of a simple dermatitis, the lichenification of any pruritic affection, etc.

A strikingly large number of dermatoses met with in practice are not textbook types. There are abortive, complex, and atypical forms. For this reason the examination of the entire surface is demanded. The obligation to avoid, as far as possible, all inferential diagnosis is also imposed upon us.

It is impossible to comment upon all the diseases mentioned in this paper; two will suffice.

Recently I have seen a giant herald patch which preceded a typical eruption of pityriasis rosea by approximately two months. Had I seen this lesion before the development of the general eruption, the diagnosis would have been most difficult. Since that experience, I have seen multiple (four) giant herald patches, accompanied by only faint generalized lesions. In each of these cases recovery was readily effected by the use of ultraviolet rays.

Concerning acne I believe we should differentiate sharply between the juvenile and the adult types. In the former, diet is of slight importance; in the latter, it may be paramount.

In some young adults, of course, the lesions represent the residue of a juvenile affection; but in the middle-aged subjects we must consider drugs, the general state of health and even the allergic response to certain foods, as well as diet in general.

❊

John L. Fanning, M. D. (Medico-Dental Building, Sacramento).—Doctors Anderson and Ayres are timely in describing some of the pitfalls of the common dermatoses. Variants from the ordinary and usual are often deceiving, at the same time interesting and instructive, and force us to continuous alertness. We recently have seen eight cases of papular pityriasis rosea at the Sacramento County Hospital Clinic, all with a severe pruritus; and the next case of an apparently typical macular type later proved to be a "phytid" eruption, a complication of an acute fungus infection on the feet.

❊

Doctor Ayres (Closing).—We wish to thank the discussants for their remarks. In this paper we have attempted to present some of the curiosities which the dermatologist occasionally encounters among the common skin disorders.

Although our paper did not concern itself primarily with therapy, I would say, in answer to Doctor Graves's comments on the treatment of scalp ringworm, that we have not found it necessary to resort to x-ray or thallium epilation. We do insist, however, on treatment of the entire scalp after a preliminary shaving, and we remove by forceps the infected hairs, instructing the parents in the technique. Our local treatment has consisted in alternating between Whitfield's ointment, tincture of iodin, Castellani's carbol fuchsin dye and 10 per cent ammoniated mercury ointment; bearing in mind the possibility of a severe dermatitis if the iodin and ammoniated mercury are used consecutively.

We make a definite distinction between uncured scabies and postscabetic persistent nodules. In a previous communication we reported a failure to find any evidence of acarus scabei or ova in excised nodules,

serially sectioned. In the cases which we reported, continued antiscabetic treatment aggravated the nodules; they were finally cured either by fractional x-ray therapy or by electrodesiccation.

As pointed out by Doctor Chipman, pityriasis rosea may exhibit very unusual manifestations. Occasionally pityriasis rosea may be imitated by an arsenical dermatitis, or by a generalized phytid eruption as noted by Doctor Fanning. I agree with what Doctor Chipman says regarding the relatively slight influence of diet in adolescent acne vulgaris. While it is true that the most rigid and restricted diet may fail to improve a case of acne, I believe, however, that excessive indulgence in candy, sweet drinks, etc., may aggravate the eruption. Certain adult types of acneiform eruptions, or what might be called acne urticatus, are undoubtedly due to food idiosyncrasies of an allergic nature. We have seen several such patients who were relieved by the avoidance of certain specific foods to which they were sensitive, after prolonged x-ray therapy had failed. Cleveland White of Chicago has also recently commented on this condition.

"HEALTH INSURANCE"—PRO AND CON*

BEING SPEECHES MADE AT THE SPECIAL SESSION OF THE HOUSE OF DELEGATES OF THE CALIFORNIA MEDICAL ASSOCIATION AT LOS ANGELES, MARCH 2-3, 1935

Remarks by Rodney A. Yoell, M.D., San Francisco

SPEECH NO. I

Mr. Chairman and Members of the House of Delegates:

I think, without indulging in the usual parliamentary preliminaries that tend to confuse, and without resorting to some of the arts and devices of those that do, I will proceed directly to the subject by discussing the fundamental issues. I think we can safely say that the reason that we delegates of the medical profession in California are here assembled in this city today is to decide the question of social health insurance, and to discuss the care of the indigent as it may bear a relationship to certain aspects of the problem.

I am very pleased, if I may put the personal equation into the situation, to find that there will be opportunity for an informal and frank discussion of the issues, so that when we subsequently meet we will have gone over a lot of the ground and have covered a lot of material, and will be in a far better position to evaluate the recommendations of the committees on any given motion, and finally be in a far more able position to discern the fundamental issues that have been called up here today, and to decide how those issues should be passed upon.

Now, I am going to ask you, for the time being, to forget that you are delegates, but remember that you are citizens and remember that you are physicians. I am going to ask you, for the time being, to lay aside any preconceived notion that you have on the general subject of social health insurance, and sit here with an open and plastic mind and let me submit to you, word by word and line by line, certain thoughts which I feel will convince you that the medical profession has, within today and tomorrow, to take a definite and unequivocal stand in order to do its full duty to the people, and in order to protect its own independence in the future.

I want, first, to call your attention to the genesis of this problem. Anyone who is at all cognizant with the current social philosophy knows that discussion of this phase of the general problem long antedates the present depression. We know that in this State in 1917, some of these very issues were put on the ballot for initiative decision. We know that before the Great War, and since that war, there has been an ever increasing and ever growing and swelling tide of literature not only in the lay, but professional journals, and in sociological works—an ever growing, ever increasing volume of literature in the newspapers and in other publications, all of which point to the fact that the public is certainly conscious of an existing medico-economic situation which demands relief.

Now, I submit to you that, in a country such as this, with an electorate that has freedom of access to the polls so that it may express its every wish when the public and the people comprising that electorate make up their minds to decide an issue, they go to the polls and decide that issue, and from then on that decision, once given, becomes the expressed social wish, and it becomes the law.

Again, I submit that it is imperative, in discussing this problem, to make two diagnoses—the one a social diagnosis, and the other a political diagnosis. The social diagnosis is this: that all trustworthy surveys and studies, including the survey and study made by your own Committee of Five, have proved beyond the peradventure of a doubt that almost 80 per cent of the people of this State have family incomes of $2,000 a year and less, and that 55 per cent of those people have incomes of $1,200 a year and less. It has also been proved beyond any question that all standard prices, particularly in the commodity market, and at a subsistence level which is necessary for a man to support his wife and his average family of two children, must range well above $1,452 up to $1,554 in yearly income. Those figures are the figures of January for this year, based on a study incident to wage arbitration. However, as far back as 1928 Mangold of the University of Southern California made a survey during the peak of the boom, and his figures coincide closely with the figures obtained in the recent study. Now, the point is this: You know and I know that it is absolutely impossible for a family with an income which is just within a few dollars above or below the subsistence level to face a major illness and secure proper health protection without skirting the edge of bankruptcy; that whatever small interests they may have in life, that whatever small equities they have, with the cost essential to an American standard of living, when faced with a major illness they almost immediately become candidates for indigency, and are either forced to put themselves into debt, with the result that they do not get the necessary service or the physician is unpaid for rendering the service, and the hospital is unpaid, and the individual is forced to declass himself, to step out of the self-sustaining bracket and to go into the bracket of the semi-indigent, burdened with debt.

These are the essential facts of this problem. We know that on an individual basis it is absolutely impossible for the average family individually to finance the cost of a major illness; but it is possible, by a coöperative effort, to provide adequate medical care and to protect themselves. The people being conscious of the fact that they cannot accomplish this thing individually, but that they can accomplish it by coöperation, are demanding the right to the coöperative purchase of health protection. What a man cannot do on an individual basis, but can do on a collective basis, if socially necessary, he will do. It is absolutely basic economics that to protect the welfare and livelihood of his family he will use collective action.

There is a parallel to be drawn here from history. I wish to call to the minds of some of you the not too famous name of Tolpuddle. This was the little British village in the middle of England in which the first labor union, in the early part of the nineteenth century, was formed. . . .

Now, we have here today in California an exactly similar situation, an absolute parallel. We have abundant proof that the people of California are demanding the right to the coöperative purchase of health protection, and we have abundant evidence that they are going to have laws passed that will permit them to exercise that right.

In the face of the exercise of that right, the medical profession can do either one of two things. It can either oppose and seek to block the exercise of that right, which would be a gesture of sheer futility, or it can see that, in the exercise of that right, no ex-

* See also editorial comment, on page 473.

ploitation and no inequity is practiced on the profession. In other words, the profession can see that if these laws should come, and if they must come, that they come cast in a mold acceptable to the desires of medicine, not alone with the view of the medical profession's interest, but also in our duty and relationship to the public.

You must remember that we have a degree of doctor of medicine, but we hold a license from the State to practice medicine; and it has always been the tradition of medicine that the profession owes to the public a certain duty. Now, if it can be shown—and it has been shown by survey after survey—that a barrier exists between the family on the one hand, and adequate medical protection on the other, and that that barrier is a financial barrier and it can be drawn aside by the application of the insurance mechanism, if that barrier can be withdrawn in that fashion, then, unless some inequity falls on the profession, it becomes the duty of the profession to seek the removal of that barrier in the interest of better medicine rather than see that the barrier is kept in being. . . .'

Therefore, I submit that if all physicians have an obligation to support laws for compulsory vaccination, if we have an obligation to support laws for the sanitary distribution of milk, if we have an obligation to protect the public from fraud or chicanery under the guise of cultist practitioners, how much more have we the obligation to aid the people in the removal of the barrier which prevents them from securing those services which we, and we alone, can give them? It is the sacred obligation of the medical man to remember that we are devoted to the interest primarily of humanity. It is not incumbent upon him, nor is it made incumbent upon him to serve at his self-expense; but if in aiding the people to secure decent medical service he can at the same time destroy a system which operates inequitably unto himself, he has, therefore, a double goal in urging that this barrier be removed.

I could cite case after case from my office calls and from my practice, as you all can, of men with incomes of $120 to $150 a month who have had to place some member of their family within a hospital, and have not only been worried about the pathological condition, and must carry the burden of worry concerning whether that loved one will live or die, but also the added weight of a financial hazard. They are forced to realize that it takes money to let the doctor function as he should.

Now is it the duty of medicine to come to this man, couched as he is in the lap of worry, and aid him in removing the burden that is a torture to his soul? You and I have gone into hospitals, we have gone into the home in the dark of the night, and have seen its anxious family huddled about the bedside of a desperately ill child. And we have known that all the resources of modern science could be thrown into the battle of life in favor of that child if only a sufficient expenditure of money was available. And we have seen, in all far too many instances, that we were hedged and handicapped by the poverty of the family, and we were either forced to serve inefficiently and without just recompense, or else send these people to a county hospital as indigents. In most instances these people are not indigents: it is merely illness that makes them indigent. Is it to be the position of the profession of California to stand up to these people and defend and continue a system which is damnable; to prevent the removing of a removable barrier simply because we feel that, in so doing, certain selfish and presumably entrenched rights might be hazarded?

The public can very justly come back and ask this question: What right of the profession will be hazarded? And we answer in the same hackneyed phrase, "The personal relationship existing between physician and patient." This is no answer, and we know it.

We are faced with a situation here which was very similar to the situation existing in industry before the Industrial Accident Act was passed. We are supposed to know something about the usual order of things, and we are presumed to be able to lead intelligently. I can go back about twenty-five years ago in the history of California and I can remember men in industry who were hurt in industry. . . .

As bad as the industrial act is administered sometimes, in spite of all of its defects, there is hardly a man in this room that will stand up and say that he would not rather have that act continue in being than go back to the conditions that existed in industry twenty-five years ago, and there is not a man who will not accept all the industrial accident work that he can get into his office and on to his wards in the hospital. Now, if a man is willing to accept the check given by the insurance layman before the five o'clock whistle blows, why is it that it becomes unethical after the five o'clock whistle blows? What are the refined sensibilities of the medical man that depend on the time clock? Why is it that a man is allowed to be insured in a commercial organization before five o'clock, that it is quite right and proper that a medical man can care for him, but when that man goes home and falls or stumbles over a chair and breaks a leg the medical profession should say, "You cannot set that leg at six o'clock as well as at five o'clock"? This is an assinine answer. You know it, and I know it. You men who do work for the railroads, you men who do work for the factories, and you men who do work for the mines and foundries all over this State, know that you give as good and sometimes better service to the patients that come to you under the Industrial Accident Act than you do to your private cases, and why? Because you have access to the means of the application of your scientific knowledge that you have not got with a private patient coming from the same status and the same group of population. That is true because the insurance principle makes money available. To say that the patient-physician relationship would be injured by a properly administered system of insurance is ridiculously false.

Now, I submit this: that if this insurance principle is essential and can be applied, and it does not work any injustice to the physician, then whatever tenet by which we hold in our craft as sacred duty, by whatever honor we maintain in our art, we have an obligation to work diligently to see that the people can get, on a coöperative basis, that same service that they cannot purchase on an individual basis. That is the trodden path of our duty, and that is where our fate lies. If we do not do this, such legislation will pass, and then we will be acting under the provisions of a lay commission. What is happening in the State Industrial Accident Commission? Faced by unregulated competition with commercial agencies, subject to chiseling commercial insurance companies, and chiseling doctors, where 20 and 25 per cent of the premiums at the end of the year is paid over to the employer, there is only one method to meet this sort of competition, and that is by cutting expenses; and what is the easiest thing to cut first? There is only one thing that can be cut, and that is the remuneration of the doctor. He cannot help himself. He has no more right to protest such a cut than a member of the crab fishermen's union. And why? When the Industrial Insurance Act was passed, the then so-called leaders in our profession did not write into the Act the basic fact that this was going to concern vitally the proper interests of the medical profession, and with one-third to almost forty per cent of the work coming into the hospitals and the offices of the doctors, it was essential that they should be represented adequately on any board which would administer that Act. Now, having failed under the Industrial Accident Act, when it was forming, to seize our opportunity, shall we, in the face of a similar situation, fail again today? Shall we have these laws passed, as they will be passed, in such a way that any politician from any party can lay the lash on our backs under the excuse of an economic expediency? Shall medicine come before this commission a mendicant and ask simply as a gift from political powers, and not as a right by representation, the fair remuneration of their services and just attention to their bills? Is that the position that we who have gathered from the north and the south and the east and the west of this State, who represent the profession of this State,

representing the man over the drug store, and the man in the country, shall we go back and say we have not committed ourselves?—that we have not the social vision or the social foresight to recognize the importance of this problem, and that we are going to rely upon the outcome of some political experiment for our future independence? If you do, you will find that you will be absolutely a mess of pottage in any camp of political spoilers who wish to gather around the camp fire. Will that be the answer to the men of our profession who pay our expense and honor us with representing them? And yet that is the answer as far as the Industrial Accident Act is concerned. I defy you to show me in any accredited medical journal, or in any medical meeting, any strong plea made in behalf of the medical profession that these conditions responsible for the passage of the Industrial Accident Act be alleviated. We had to leave it to the layman, and now we come out here and say, we who wish to be leaders in social thought, trust us! They have trusted us, and we know we cannot fail them. But we will fail them if with an incorrect social diagnosis we permit individual bias to cloud our reason.

Now, I want to show that some of the material which has been presented for your consideration on the subject has undoubtedly influenced your minds, and that it comes from a very questionable source. In my remarks, I will not indulge in any personalities, because this issue far transcends the importance of any man who is in this room today. It is a matter which is going to demand attention for many, many years to come, and will involve the medical fate of millions of people and the future of an independent profession. I wish to state that some of the evidence presented to you in some of the articles that have appeared in the medical journals have been biased, have been unscientific, have been inaccurate, and in some instances have been false.

I wish to remind you of a series of articles that is being published in California and Western Medicine. This series began to appear very shortly after this House of Delegates authorized the survey last May. These articles were on compulsory health insurance and were run while your committee was conducting an objective study and an impartial survey. These articles were against any form of compulsory health insurance, and were written by a man by the name of F. L. Hoffman; and these articles, because I have been perusing the literature, contain so many misstatements and so many inaccuracies as regard the factual data that I made it my business to inquire who this Mr. Hoffman was and whence came he, and I am going to submit to you the final report of the Royal Commission of Canada, the province of British Columbia; and in this pamphlet, which I will read to you, there is a direct challenge to the veracity and the integrity of the statistics and figures laid down by Mr. Hoffman when he appeared before the Royal Commission as the accredited agent of the Christian Scientists, and the same articles which appear in our official journal and are at present being published in California and Western Medicine, are as they appeared in that great journal devoted to the interest of organized medicine, the *Christian Science Monitor* of a few years ago. Now, having gone to that fountainhead of scientific knowledge to give you correct information on this subject, let us turn over the pages of the Royal Canadian Commission and see whether the statements that he made are true or are they not true, and we find this: "At the earnest request of the Christian Scientists, we accorded a special hearing to Mr. Hoffman, and his evidence will be found in Volume 3, Appendix H," and then they say: "A perusal of this evidence discloses, however, that Mr. Hoffman's antagonism to the principles of health insurance is based, not upon any authentic facts relative to the failure or success of the European systems, but rather upon a general argument in condemnation of the principles of compulsory state health insurance. The expressions of Mr. Hoffman are clearly valueless in the light of present-day experience, and indicate that his ideas of European systems have not been brought up to date."

It seems, therefore, that the evidence that he adduced was in some instances between ten and fifteen years old, and the evidence and the studies that were presented in California and Western Medicine go back further than that. It goes back to 1917. Mr. Hoffman had evidently not followed the latest development of the British system, and I will quote from the British Medical Association, which Mr. Hoffman took issue with, where they say: "Mr. Hoffman also states that health insurance in the United Kingdom has not improved the health of the people of the Kingdom," and they give the figures of the British Government; they published the actual figures from the British Ministry of Relief, and show that there has been a decided decrease in mortality and in morbidity, and they show that the gain has been most marked. In other words, Hoffman's statements were not reliable and accurate, and the Canadian report concludes with this statement: "Mr. Hoffman's criticism was merely directed to conditions which existed more than ten years ago, and which conditions have been steadily improved upon. Finally, we refer to the evidence of Mr. Hoffman in Volume 3, Appendix H, when he was closely questioned by members of our Commission. His evidence reveals, in our view, merely general statements backed up by no reliable facts." [Lays Canadian report on table.]

Now this was the man that was sought out at the beginning of your survey—the paid accredited agent of the Christian Scientists, who have always been the friends of organized medicine and of public health—to educate you on this subject. This was the man that was sought out from the entire length and breadth of the United States as the only man who could inform you as to the merits and the demerits of compulsory health insurance, a man that stood before the Royal Commission and was shown to be biased and ignorant and possibly false, upon the subject that he spoke of. In all of the breadth of this land, in all the surveys made, in all the departments of all the universities, that have spent hours, months and years studying this subject, the one man picked to inform you, gentlemen, and to help you make up your minds as to the value of the plan of compulsory insurance, was the man who represents a group that has always been antagonistic to scientific medicine, and by the very fundamental tenets of his creed always must and will be. That is the type of evidence that you have been influenced by prior to this meeting.

May I submit this, also, that the American Medical Association, knowing that the survey was being made in California, knowing that you people would have to come to some decision, put out a so-called sickness insurance catechism. I shall not point out the inaccuracies contained therein because time is too short, and I do not wish to bore you, but inaccuracy after inaccuracy is contained in that document. Apparently some of the statements of Hoffman are incorporated in that document, and here we see visualized on the stationery of the San Francisco County Medical Association, sent out by the American Medical Association for distribution to the members, active propaganda against health insurance, while we were spending $80,000 to arrive at an impartial estimate of the subject. That is leadership, isn't it?

But this attitude of antagonism and bias goes back further than that, and in proof I will quote some letters sent to the secretary of the California Medical Association by Fishbein, West & Company; and here are a series of arguments that were to be submitted, and the comment is made that since the American Medical Association and its state societies have gone on record against compulsory sickness insurance, it is extremely desirable that the views of organized medicine be made known to the voters; and then it urges that the congressmen who are now with us have political contact made with them in order that the views of organized medicine shall be made known to them. I submit this, as the type of propaganda that was sent out: A series of arguments in which the Committee on Publicity of the American Medical Association said it was not to be let out that this comes from their committee, because that would bias and prejudice

the public. In other words, they were afraid to get out in the light, but this was behind the screens when they expressed themselves, and these arguments are all against the principle of compulsory health insurance, or a sound system of social relief insurance of any character. Now, if we remember that this is the sort of material that has been handed out for your consideration, it will undoubtedly be extremely difficult for some of the delegates here to keep an open mind; but I wish you to remember, inclosing, certain irresistible facts. They cannot be escaped from! The first is that there are four bills in the Senate of the State of California calling for a social health insurance act. There are four counties in this State that have elections for proposed new charters which makes it absolutely mandatory on the supervisors to receive any resident of the county who wishes to come into county hospitals, irrespective of his personal income; in short, that any person be admitted to the county hospital. There is also the question of an initiative on the part of the Epic people, who wish to put on the ballot of this State the question of throwing open the county hospitals. In other words, there is an organized effort to make a Kern County of the entire State of California. And we have been told, on two occasions, by the Interim Committee that they expect our leadership, and that if we come in with a fair bill they will recognize the edicts of the profession. They are down in writing as to that, and they have also expressed themselves privately.

Now what shall the attitude of medicine be? Shall they go ahead and support a system of voluntary insurance which has always failed? We can talk about that later. Your committee was instructed to bring in a plan and a bill, and the proponents of the voluntary plan have not one shred of evidence showing that there is anything more than a plan of a nebulous welfare bill. There is no plan presented in the majority report of the committee. There is a general outline and a statement of principles, and there is the hopeful wish that legislation, which might make this fanciful proposal possible, could be gotten through, but there is no provision in the Assembly or in the Senate to provide that legislation nor any hope of getting any.

Our opponents talk about political domination under a compulsory system. We who do some industrial practice are subjected to a competitive lash far worse than the sting of political domination. We have, under the Industrial Accident set-up, no right to representation on the administrative board, nor can the Commission regulate cut-throat competition offered by certain commercial companies against itself. These companies can reduce the premiums offered to industry because they can get chiseling, pandering doctors to work for them at fees below the rate granted by the Commission, and thus underbid any decent fee schedule.

Unless some sane legislation is worked out preventing a repetition of this reprehensible and unfair system, it will carry over into measures intended to care for the health of the mass of the whole people whether industrially insured or not. If collected efforts are to be directed against the hazards of illness, let the laws providing such a system be soundly drawn and let us aid in framing them.

If the county hospitals are going to undertake the task—and apparently they are—and if we let them succeed, we shall have a system of State medicine intolerable in its viciousness. We have had our bitter experience in Kern County and other counties, and the men here from those districts can testify as to that sort of politically dominated competition.

So, before we make our final decision, remember three, and only three, points: that there is an economic need and that this need will be answered by the people; that there is the right to the coöperative buying of health protection, and people will exercise it and write it into the law, and that the medical profession has one objective—to protect itself in the writing of such a law, and in insuring, in the enactment of any system, a legal and recognized status that will forever prevent its exploitation. If we agree with these essential points, let us take a position in favor of a mandatory system of health insurance, with technical control in the hands of the profession and the control of any pool of wealth from which funds are used to furnish medical care under the direction of a commission. Then medicine will thereafter be free; but if we do not do that, we will fall under the bureaucratic system of State control, and will be given over unto the commercial groups, which can buy and sell our services like chattels. We have our choice. Let us make our decision wisely!

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Remarks by John Hunt Shephard, M.D.
San Jose

Mr. Speaker and Members of the House of Delegates:

The terms "state medicine" and "health insurance" are not synonymous, and we should be very careful not to use them as such. Fundamentally and basically, they have very little in common. State medicine is a system of providing medical service for part or all of the subjects of a political unit, administered by political employees, the expense of which is defrayed in whole or in part by funds derived from some general or limited tax levy; whereas health insurance is the conversion of an indeterminate, unpredictable loss resulting from sickness into a determinable predictable expense borne by the individuals who may derive benefits therefrom.

In other words, State medicine is paternalistic, providing in whole or in part a necessity for certain classes at the expense of other non-beneficiary classes. State medicine is exemplified in several European countries, but we do not have to go abroad to see the inequities, injustice, and incompetence of such a system. We only need to view our Veterans' Bureau, furnishing medical hospital service for non-service connected disabilities, to get a clear picture of this unsound and ill-advised system. We do not have to leave our own State to study the workings of health insurance. We find the principles of insurance being applied in the furnishing of medical and hospital care to the employees of several large corporations. The potential beneficiaries pay the cost. The service rendered them is of a superior quality, and those rendering the service are adequately compensated without waste, extravagance or graft.

For eight years, in association with two other doctors, I was engaged in similar health insurance work in northern Idaho. The various employers made wage deductions from the employees, turning the same over to our organization. We furnished unlimited medical, surgical and hospital service for the sick and injured employees. We delivered excellent service and received compensation equivalent to the then prevailing private practice fees. The only dissatisfied or disgruntled individuals were a few competing doctors who claimed it was unfair competition, and I agree with them. This was compulsory health insurance, and was the most pleasant and satisfactory practice I have ever enjoyed. At the height of our business, we had over six thousand employees under contract. At one time we attempted to establish a group under voluntary health insurance. We had established the reputation for giving highly satisfactory service; we were personally known to practically all of the residents and served over half of the population in that vicinity who were not under contract with us. We advertised our voluntary health insurance plan in the newspaper, by posters in the sawmills and logging camps, by posters in our offices, by word of mouth and by personal solicitors, but were unable to secure a large enough membership to make it worth while. Only a few of the married men under contract with us would subscribe for a voluntary membership for the members of their family. Their incomes were small, 25 cents per hour being the basic pay for common labor at that time, and the monthly premium necessary for us to assume the risk seemed unsparable by the majority. However, when members of their families required medical service, the percentage who paid for the same was as high or higher than the same class of workers today.

From this personal experience, under most favorable circumstances, I do not believe that any voluntary health insurance plan will be largely patronized by the group of people mostly in need of it, and if a solution of our present difficulties is to be found in any form of health insurance or State medicine, it must be through a system of compulsory health insurance.

There is much discussion regarding what economic group should be included under any system of health insurance. Some claim it should be limited to those earning less than $2,000 per year. Others set the limit at $3,000 per year. Personally, I believe there should be no limit. If we endorse and work for a plan of health insurance, it must be as nearly ideal as can be conceived. To me, that means a plan providing complete health service, preventive as well as curative, for every individual from birth to death. I fully realize that it would be poor judgment and would probably result in complete failure, if we attempted initially to institute such a complete plan, but should we not have the entire picture in mind when laying the foundation?

Today we are making the "have's" pay for the "have not's." We are serving many whom we do not charge, and many more who do not pay us, but those from whom we do collect are paying for what we like to speak of as our "charity" service. If I could be paid a modest sum for the services which I render to the low-income group, I would gladly forego the occasional large fee that I receive.

We must look upon ourselves as the functioning part of a public service and, as such, make our services available to all, not by gratuitously serving one and excessively charging another, but through some means or plan whereby each self-respecting, independent individual, can provide through his own efforts adequate medical service for himself and his dependents; and compulsory health insurance, under the control of organized medicine is, I believe, the only answer.

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Remarks by A. R. Kilgore, M.D.
San Francisco

Mr. Speaker and Members of the House of Delegates:

I think we are all agreed that a policy of *laissez faire* will not do. A definite economic problem has grown up in this country of financing the care of illness for the low-income group. It is not a problem of the depression. It existed before, and has only been made more acute by the economic situation. Where there is a real social problem, the solution will sooner or later be found; and I am quite in agreement with other speakers that the only final solution to that problem is health insurance, and even in agreement that eventually it will have to be compulsory health insurance.

But the central consideration which we ought to keep in mind is that, for the success of any such system, there must be medical control. And we ought to think more clearly than some of us are thinking about medical control. A medical control, consisting of management by politically appointed doctors of medicine, would not be satisfactory to me and should not be to you. A control limited to the establishment of standards of practice, of the discipline of doctors, and not extending to control of the compensation of physicians, control of the income limits of the people to whom insurance is to be offered, etc., will not be a satisfactory control.

Anyone who has read the history of health insurance abroad must be convinced that just to the extent that medical control has been preserved by the organized profession, just to that extent have systems been more or less successful. Where medical control has been lost, and the systems have been operated under management by lay groups, either government or private, the service has been unsatisfactory to all concerned.

Now, what chance have we of getting the necessary control if compulsory health insurance is adopted today? If you talk about medical control with lay people, you will be surprised to find that our argument does not appeal to them. For us to attempt to gain complete medical control of health insurance sounds to the layman like an attempt on our part to set up a medical trust and dictatorship. It is difficult for the layman to understand that medical control is necessary for the satisfactory working of the plan to the people whom it is going to serve.

Even in the Advisory Council to the California Medical Association's Committee of Five, well-informed as these gentlemen are, the idea was very strong that the control of compulsory health insurance should not rest with the medical profession. They are willing enough to place somewhere down the line a medical advisory committee or a medical director, appointed by the political governing board, charged with the maintenance of medical standards and the discipline of doctors, but they are not willing really to turn the plan over to medical control. Even Doctor Yoell, whose bill a few weeks ago called for a majority of physicians on the governing board, now asks for two physicians out of five members, not appointed by the California Medical Association or even nominated by it, but from a list supplied by the board of regents of the University of California. Perhaps no more impartial body could be found in this State, but it is not the organized medical profession. And even at that, Doctor Yoell is asking for two doctors on the board, not hoping to get the bill written and passed in that form, but expecting to use this request for bargaining to get whatever shreds of medical control can be obtained from an unwilling legislature.

Think of the amount of money involved. With a million and a quarter employees in industry, plus their dependents, between fifty and a hundred million dollars a year would be collected and spent. Do you suppose, for a moment, that you can keep the hands of a group of politicians out of a fund of fifty million dollars a year?

Speaking of money, let us ask ourselves, before we endorse compulsory health insurance, what the costs of administration under a politically controlled set-up will be, and where these costs will come from. Go to the British plan and find that a little more than 50 per cent of the amount of money paid to doctors is the bill for administration. That money does not come from tax funds. It does not come out of thin air. It comes out of money that ought to go for medical service to the people, and it comes out of the compensation of the doctor.

If you want an example of what happens to doctors' money, look at the experience of our Board of Medical Examiners and its fund of $200,000, built up from examination and registration fees paid by us, and later used in part to aid in the payments due on a San Francisco office building purchased by the State.

As I said a few minutes ago, the argument for medical control is clear to us, but does not appeal to the layman, and there is very little use of our making it. But there is a line of perfectly clear and logical reasoning which should appeal to intelligent laymen. If we are going to establish health insurance, we want to set it up as nearly right as we may. Some mistakes in any law will require correction, but we ought to make them as few as possible, because mistakes under legal enactment are not easy to correct.

We cannot use a foreign system like the British for a model. A service limited to care by general practitioners would not and should not be satisfactory to Americans. The problems of organization and administration become infinitely more complex when to care by general practitioners is added services by a complete organization of specialists, to say nothing of adding hospital care as well. I could cite in detail many of the problems presented without being able to furnish answers to these problems. Only experience will tell us how they should be solved. The early years of operation of a health insurance service will give us an enormous volume of information which can be obtained in absolutely no other way.

It seems to me perfectly reasonable and fair for this Association to say to the State of California that we think no one, ourselves included, knows how a compulsory health insurance law for California should be written. Therefore, as a part of our obligation to the people of this State, we want to work out in practice

many of these difficult and complicated problems before the final law is written. And we will do this on our own responsibility on a voluntary basis.

We have heard a good many times that voluntary insurance has always failed. It may not have taken in as much of the population as should be insured, but one can hardly say that the railroad and other great commercial organizations operating health insurance for their employees have failed. We may not approve of some of the commercial health insurance organizations in California, but we can hardly say they have failed. We have seen very little experience in the operation of health insurance by the organized medical profession, but the one plan I know of in operation—that operated by the King County Medical Society at Seattle—has not failed. It is insuring 21,000 industrial employees (all but five per cent with incomes less than $100 a month) and paying to its doctors a substantial sum of money in medical compensation, most of which they would not receive except for the insurance machinery. They have made mistakes and learned many lessons, but since their plan is one of their own they have not had to go to the legislature to correct errors.

I should go one step further in our declaration of policy. I should like to see us offer to work out the problems of health insurance in the school of practical experience on our own responsibility. But we should also say to the Interim Committee of the Senate that if, in their opinion, the temper of the people and of the legislature is such that they must introduce a compulsory plan at this session, we will sit down with them and help them write that plan in accordance with principles which we adopt at this session.

I want to leave this thought with you again. The essential fundamental for a successful plan is medical control. Control goes with financial responsibility. If the State assumes financial responsibility, it will assume control. If we want control, at the present time we must be willing to assume responsibility. Which alternative would you shudder at most—assuming a financial risk or giving up now forever the control of medical practice by the organized medical profession?

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Remarks by Dewey R. Powell, M.D.
Stockton

Mr. Speaker and Members of the House of Delegates:

From the resolutions that have been presented and read at this session, and from the discussion which we held yesterday and which has gone on this morning, there is ample evidence of a very decided difference of opinion as to the questions at issue. I am very much surprised that there are still a few of our number who believe that we can sit back in smug complacency and continue the present system. This policy of *laissez faire* is a surprising one to me, and how anyone can expect that the medical profession can continue on in the present *status quo* and remain unruffled and uninterested, as many have been, in changing social conditions and changing public opinion, is beyond my conception.

I have the highest regard for the profession in which we are all engaged, and none has a keener appreciation of the achievements of the past. If I had to do it all over again, in spite of the cares and the worries and the trials and the vicissitudes, I would again elect to study medicine and enter upon its practice. Yes! I have as high an opinion of our profession as anyone, but we in San Joaquin County, gentlemen, have no delusions of grandeur as to the place that our profession holds in the public mind. We have ample evidence that we have lost much of the prestige that formerly was ours, and we must zealously guard the place—a high place, I am happy to say—that still remains to us in the social structure of this State. But this problem that we are discussing today concerns not only ten or twelve or fifteen thousand members that are practicing the healing art—it concerns virtually some five million of our lay population; and while the interests of our profession must be adequately safeguarded, let us keep in mind that our primary duty is to the public at large. I believe that I can safely conclude that the great majority, even a two-thirds or three-fourths majority, concur that the policies of doing nothing, that *laissez faire,* have no place in our deliberations today. We must formulate and express a public opinion. We owe it, gentlemen, to our members back home that are awaiting the result of our deliberations here today. We owe it to those younger men in the profession who face the future. We owe it to those boys, perhaps some of your boys, who are in medical school or in preparation therefor, and who expect to continue on in our footsteps, and we want to give to them the heritage of a professional unhampered by lay restrictions and by regimentation. We must not evade the issue, but with clear thinking and with shoulders erect and head high we must take a long view perspective and formulate an expression of which we may well be proud.

Now, what alternatives are open to us? We can agree that we must utilize the insurance principle of periodic payments to meet unexpected and unpredicted risks and expenses. We have two alternatives under the insurance principle. We can vote for the resolution under discussion, in favor of the voluntary plan. But let me point out to you that by their own admission they, the proponents of this plan, admit that it is inadequate. They state that at the present time we can only take up the matter of hospital insurance. And I ask you if you gave to us, the delegates of San Joaquin County, the right to establish, under the authority of the California Medical Association, a system of voluntary hospital insurance in San Joaquin County, how could we compete with a county hospital finely equipped and wide open, admitting any citizen of the county, irrespective of his financial status, free of charge? How could we sell such a voluntary insurance? Gentlemen, it would be absurd to broach it to the profession or to the public of San Joaquin County. I, representing the San Joaquin County Medical Society, presented our viewpoint to the County Board of Supervisors not long since, and the chairman of the board (who I know holds me in highest personal regard) said to me: "Doctor, if you have any idea that the policy of this board does not adequately represent the great majority of voters of this county in the policy maintaining a wide-open county hospital, we shall be very glad to place the issue on the ballot at the next general election." Did the medical profession of San Joaquin County accept that challenge? Gentlemen, we know better. We should have been defeated, ten to one, had it come to expression of opinion at the ballot-box. A system of voluntary insurance is so far inadequate as to be pathetic. By their own admissions the proponents of voluntary insurance state that enabling legislation will be necessary before it can include the all-embracing medical and surgical care. Have you read this supplementary report which Professor Dodd's survey staff submitted to the Committee of Five that was passed to us yesterday? Do you recall a sentence therein that there is no assurance that such enabling legislation could pass, because it might well be interpreted in the nature of a monopolistic control on the part of the California Medical Association, and might well stir up a hornet's nest of opposition to present it to the legislature? There is no assurance that such enabling legislation could be passed.

Voluntary hospital insurance again would necessitate the California Medical Association entering into the insurance business and obligating itself in a financial way, which might lead into stupendous and uncertain amounts. And I am here to say to you, gentlemen, that many of you who desire adequate voluntary hospital insurance shudder at the thought of members of a scientific organization, primarily dedicated to the advancement of science, exchange of ideas and the better understanding of our own profession, entering into the field of finance and insurance and obligating themselves and the funds and the surplus that we have built up over a long time to this new venture in which we have had no experience, and the costs of which are most uncertain. Yes, I think I can say that we all

shudder at the thought of assuming such a financial obligation to the people of California.

Again, I will call to your attention that the voluntary systems of insurance have never worked successfully on a large scale, while on a small scale the degree of success attained has been due almost directly to the proportion of compulsory features that they contain, particularly in the selling end and the collection of the premiums. Every voluntary system, gentlemen, has been an entrance wedge of only shorter or longer duration toward the inevitable solution of compulsory obligatory insurance. Therefore, we must turn to the second possibility, the question of compulsory health insurance; and if we are to reach this group in the low-wage brackets needing it so badly, if we are to protect the profession and the community against the improvidence of those who are unfortunate or irresponsible, if we are to put it on a broad financial basis with a proper spread of risk that will make it insurable, then that system must be compulsory. But, gentlemen, one of the resolutions that has come up hereafter takes even a broader view, to which I am willing to subscribe: that we can very easily recommend a system mandatory for some groups and voluntary for other groups, and with our committee in conference with the Interim Committee of the Senate work out a system which will safeguard the interest of the profession and meet the problem at issue.

I feel that our profession is to be complimented as to the confidence which this Senate Interim Committee has placed in us, for we have their assurance, both oral and written, that they will accept our plan with a great deal of sympathy, and will earnestly coöperate with organized medicine in this problem. So, gentlemen, we cannot simply mark time. We cannot delay the issue. The legislature reassembles tomorrow. The Senate Committee is waiting for an expression of opinion. We must not evade the issue nor hedge. Let us instruct from this House of Delegates today that a committee be delegated to confer with this Interim Committee and form a system protecting and safeguarding the profession and offering mandatory insurance, obligatory or compulsory, if you like, to certain groups of our population, and voluntary to others. I want the privilege, gentlemen, of returning to my home in Stockton, and there tell my fellow doctors about my confrères in this convention, tell them that the majority of the practitioners of this State, as represented here in session, have a broad viewpoint, and a long-time viewpoint; and that they recognize the necessity of changing conditions and the changing social structure. And I want to tell them that we have instructed our committee on broad lines to meet the problem at issue. I want to tell my boy in high school, who is looking forward with pride to following the tradition of the practice of medicine, that we are going to do something for him and his pals by saving the profession from lay control and regimentation.

Gentlemen, I have confidence in the unexpressed opinions of those here in this session who have said little and thought much. I have confidence in your judgment.

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Remarks by Daniel Crosby, M.D.
Oakland

Mr. Speaker and Members of the House of Delegates:

This is not to be a discussion of personalities, but I cannot come before you without expressing my deep respect for the industrious study of this subject made by Doctor Yoell, even though many of us are unable to agree with his interpretations or his conclusions.

We have various interpretations of the success of insurance measures abroad, but even the most enthusiastic must realize that European psychology is not transplantable to California or to America. We must weigh the problem as it faces us, and determine whether a health insurance statute upon our book—with our present understanding—can offer a constructive solution.

The earning power of the doctor cannot enter seriously into this question. Service to the community is paramount, and earning capacity or the lack of it cannot constitute an argument for a health insurance act.

But the earning power of the people of California is greatly to be considered. Our tax bills are mounting, and wherever health insurance laws have been enacted the tax burdens have greatly risen.

California, in 1933, faced an enormous tax burden. Here are some of the figures: California produced from petroleum $143,000,000; from manufactures, $83,000,000; from the citrus crops, $50,000,000; from other orchard crops, $102,000,000; and from other field crops, $160,000,000—a total of $465,000,000, or $125,000,000 less than our present tax bill.

Rapidly mounting costs, the notoriously inadequate information submitted to all of our legislative bodies, the absence of significant criteria in our own land, the well-recognized complications in the health insurance structures abroad—although these last are so commonly minimized by our self-appointed, enthusiastic, crusading guides—are probably among the significant items which have prompted the none too conservative Madam Perkins to announce: "There will be no hasty legislation in the matter of health insurance."

Even the President, in his New Deal enthusiasm, hesitates about coming forth with a health insurance program.

We are in the midst of economic puzzles that confront the universe; the medical problem is but one of these, and we must not dare let ourselves be led into the quagmire of ill-considered health legislation in the hope of creating a panacea.

Unbridled enthusiasm can nullify the effect of the most industrious investigation; and when flamboyant oratory becomes the motivating force in driving home conclusions based upon ill-considered data, we are reminded of the saying of Montesquieu: "I love the peasants because they have not been sufficiently educated to argue erroneously."

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Remarks by Nathan G. Hale, M.D.
Sacramento

Mr. Speaker and Members of the House of Delegates:

I had no intention this evening of coming before you and presenting any argument on the subject. My oratorical neighbor, my good friend Doctor Powell, presents a case that, to those in the neighboring counties, has been a source of worry for years. Doctor Powell has presented the facts in San Joaquin County, but he has not presented the desirable facts as they relate to the private physician who has no control over the San Joaquin County Hospital. There are doctors in San Joaquin County who feel that such a situation has been countenanced so long that at the present time no other method is available; and in my opinion no other method ever will be available for any medical group so long as you present a charity hospital to the Supervisors without supervision of local county medical units, with proper care of the patient as their primary motive.

As vice-president of the Chamber of Commerce of Sacramento County and the chairman of the Public Health Committee, I have, for a period of three months, been making an economic survey of their public health situation. We have collected statistics, through the aid of the Bureau of Vital Statistics of the State of California and at no expense to the State, which present an entirely different aspect to this subject. In order to set forth the health situation, one has to investigate temporary poverty not only as it relates to the State of California, but in each individual county. For instance, in October, 29.9 per cent of the population in Los Angeles County were on temporary relief, while in some of the counties in the northern part of the State the temporary relief is less than one per cent; which means that the burden that is placed upon the taxpayer is a great deal more in those counties that have not been improvident during the good times as compared with those counties that have been improvident, if the taxes for such are distributed in a state-wide manner.

The Sacramento Committee on Public Health was chosen by the Chamber of Commerce of that city to represent every group—an osteopath, a leader of the Church, a member of the school department, a dentist, and an optometrist, etc. After being passed as satisfactory by the board of censors of the County Medical Society, a report was unanimously adopted. It was then presented to the board of directors of the Chamber of Commerce, composed of twenty-one prominent men representing the city and county of Sacramento. The Chamber of Commerce directed that copies be sent to as many of the lay people as we wished, and to our representatives in the legislative body. The member of the Health Committee who was in charge of the public schools asked that mimeographed copies be presented to all the teachers in Sacramento.

I believe I am safe in saying that we shall never get away from individualism in this country. I do not care what Europe does. After all, we are not following the policies of Europe, and we have not since we dumped the tea out in Boston harbor. The question is, necessarily, whether Sacramento County is doing her share in meeting the present emergency in caring for the sick and the percentage of financial distress in Sacramento County, as compared with distress evidenced in other like communities.

With your permission, I shall read some paragraphs from the report to which I have already referred, in the hope of adding emphasis to some of the matters on which I have just spoken.*

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Remarks by Harry Wilson, M.D.
Los Angeles

Mr. Speaker and Members of the House of Delegates:

. . . We are all aware of the fact that the care of sickness is the sixth industry in the United States, and such an industry is open to exploitation; that 125,000 doctors of medicine are desiring to maintain a position of control in comparison to 875,000 lay or technical associate workers who are helping to render care to the 120,000,000 people, and who are a little disinclined to see the control remain in the hands of the medical profession; and that there are other interests which have been busily at work in this country for quite a few years, long before this period of depression, in an attempt to foster theories upon this country, following the precedent in other countries of the world that do not happen to be so fortunate in their financial position.

Fundamentally, I am a nationalist. It is intolerable to me to think that we need to lower our standard of living to compare with that of India, China and central Europe, and change other social ratios and working conditions to conform to some of those less fortunate countries. It does not seem that the cry for a change is coming from the medical profession. I think we have been susceptible to the influence and the pressure that has been brought to bear upon us. If you look back for only a few years you will realize that the Costs of Medical Care Committee, funded by persons who had a definite, preconceived plan and purpose but were not interested in the factual data developed in the study, brought that report into being and brought the committee into being in a time of unprecedented prosperity. Then, realizing that they had made a mistake in tactics, they shifted the attack to public news items and propaganda to bring us into subjugation that we might conform to their ideas.

Unfortunately, I am sorry to say your Committee of Five has been guilty, in my opinion, of expending $32,000 of your money and $56,000 of SERA money, funding a study that has been devoted to the publication of the expressions of men who had similar preconceived ideas. The report of the Advisory Council that has been submitted to you, the preliminary and supplementary report, is not the report of the Committee of Five of the California Medical Association. It is the report of the Advisory Council and of the staff. Most of the opinions expressed have been the opinions that each of those gentlemen have held for some few years. They are based, in my opinion, not upon the data assembled, but upon social theories that have been held and are being taught by academically minded men who are not living in a life of reality, so far as going out and selling their services in the commercial competitive field is concerned.

To my mind, this is a problem of theory versus practice. All of us are susceptible to the expressions of theory. They read well, but when we attempt to adjust those social theories to the actual practice of submitting them to a politically controlled mechanism, with other than professional men in the saddle, with lay hands on the reins, who may not be actuated by the same altruistic theories and feelings that cause a man to select medicine as his field of endeavor, then we are up against a real problem of practice; and practice and theory do not often work well together. Even Marx stated years ago, when he gave expression to his theories, that it would be centuries before, in practice, they could be found acceptable.

Now, I think the medical profession is willing to participate with society in a change of living conditions, provided we participate as a unit along with other units; that we are not selected and our services will not be the only services made subordinate to lay commissions appointed by the Governor, and subject to change by each incoming legislature every two years, with the injection of the lay mind, instead of a group of doctors, as the dominating factor as to what constitutes good practice. Most of us are fairly willing to be told how to do a scientific act in medicine by a man of our own field of endeavor who is better equipped than ourselves; but most of us are rather decidedly opposed to be told by a Ph.D., or by a poorly trained individual who assumes a knowledge that he does not really possess, how to perform the practice of medicine. Medicine is only about fifty years old in its modern conception. We have had the daring to conceive many new things in spite of the fact that the medical profession are ostensibly a conservative group. Properly so. I told Mr. Edwin E. Witte, executive director of the President's Economic Security Committee, in Chicago, that if there was any criticism of the medical profession for an apparent unwillingness to coöperate with his committee in solving the social problems, he must remember that he is dealing with a conservative profession. If we accepted every nostrum for the sure cure of the illnesses of mankind, as well as correct advice of some of the gentlemen who would like to tell us how to practice, the useless, harmful drugs that would be forced down the throats of the defenseless public would be comparable to the social abuses that compulsory health insurance will bring to all of us.

I think that we need to have courage in handling this problem. We are not "defeatists" in this country. It is inconceivable to me that we should throw away in one move a heritage that has allowed us to attain to a cultural development with standards of living that have not been reached by any other nation in any other part of the old world. I do not see why we should subordinate ourselves to theory, rather than to have the courage to stand up and fight for the things that we believe in our hearts are fundamental to progress. I do not think that there is a man here, if he would face the fact, but who believes that compulsion is injurious to the field of medicine, and that we are not going to subordinate the practice of medicine to lay commissions. If we could write the most perfect bill in the world and then trade it off on the floor of the legislature, when we got through with the best trades with industry, the cultists, the hospitals, and various other groups having different concepts of a perfect bill, and if we excluded the voice of patronage and the political manipulation involved, we would all come to the same conclusion: that the public welfare of our patients in the future will not be served better. Any comparison to European precepts of health, and so forth, will not help us in our problems in this country. Any betterment over there is a step forward in those countries.

* A digest of this article was printed in the April issue, page 241.

Now, just what does legislative enactment mean? It has been stated today that we can secure forever medical control of standards. I do not know of a provision of government that is perpetuating, that is going to prevent the Governor from leaving off the two possible medical men of the Commission. There is no restriction on the legislature or the vote of the people by use of the initiative for the perpetuation forever of professional control. Forever, stretched over two years of time, is an abuse of poetic license, it seems to me. You know the usual fate of legislation. There is no use enlarging on that. You know the difficulty we are going to have if we turn this bill over to the Legislative Committee and the difficulties that committee is going to have in trading and attempting to maintain the things we want, in the face of an almost unanimous opinion of our Advisory Committee of economists, who believe it is against their best interests to permit us to have as a class any representation upon the Commission. They cannot see why the doctors of medicine should have any representation. It is true, as a matter of political expediency, they have shifted their views, and with it their recommendations on paper as submitted to us in order not to permit their recommendations to be rejected, just as Doctor Yoell has submitted a final draft, and he varied it from the original draft; and the original one, I am sorry to say, compared almost word for word, and provision for provision, with the Epstein Compulsory Health Insurance Bill that has been submitted to many of the other states in this country. Whether the suggestions and advice were heeded at that time, or whether the changes were for the purpose of political expediency, I do not know; but those are the facts.

Now, the actuarial estimate. It would be rather desirable for us to know how much of a fund might be built and divide the fund into the various figures. I am sorry that the committee is grossly lacking on any report on the actuarial status. It is true, I believe, that none of the insurance companies have been willing to underwrite health insurance if service was rendered. I heard William Shepherd of the Metropolitan Life Insurance Company (who, I imagine, is an authority on this subject and has a tremendous amount of information available) state that it was probable that the costs of this insurance might be an actuarial undertaking, but it was one of the least known of the insurance problems.

As a lay actuary, and hoping to bring to you some little vague study of what might happen to us if we submitted the care of the people to compulsion, I have broken down several figures. I have taken first the statement rendered to us by the survey staff that there were approximately 1,300,000 workers in the State of California who would come under the provisions of the insurance bill that has been presented to you by Doctor Yoell. One million three hundred thousand workers at $60 per year, $5 per month, and that is a rough approximation of the probable percentage of the proposed minimum written into the bill. That would produce a fund of $78,000,000, less the administration charges; and I include only $6,000,000 for administration charges, whereas, if the costs are anywhere near average, it would be $12,000,000. However, allowing $6,000,000, there would be $72,000,000 left, and dividing that by three—because it has been fairly well demonstrated that out of the $30 per capita cost to render care in sickness, a little less than one-third of it is available for professional services, that is, for the doctors of medicine—would leave a fund of $24,000,000 that might be available for professional services. Counting eight thousand doctors in this State (and that is an unfair figure to use, because any bill that will be passed will undoubtedly include also the physicians and surgeons who have degrees of doctors of osteopathy, and it is barely possible that even those who have licenses to practice chiropractic will force their way into it) and taking it in its best comparison, counting only the eight thousand doctors who are eligible to serve under this bill, and dividing these eight thousand into the $24,000,000, we find a gross annual income of $3,000. It costs 50 per cent to practice medicine, so the net potential income would be $1,500 per year per doctor out of 50 per cent of the paying population, without any provision for the dependents and taking only the workers, leaving some 20 per cent of the population in the indigent class and the bracket just above which would not be provided for in the insurance plan; and considering that the exemptions are slightly less than the workers who have been insured, you would be forced then to attempt to extract from the 19 per cent of the population that come above the $3,000 a year class the rest of the costs that you are going to live on, take care of your families, educate your children, send them, possibly, to medical schools and make doctors out of them; and that would mean that 400,000 persons (adults who are income producers) would have to pay more than $200 per year in order to bring to the doctor the potential income of something less than $2,000 per year net. . . .

It is obvious that a fee schedule of costs, about 50 per cent, will be the standard fee schedule that will likely apply to the remainder who are able to pay cash. It is also obvious that the returns are going to be so slight and so disappointing that there are only two or three inevitable results. The medical profession is going to have to do as they are doing in Great Britain—join federations of labor and labor unions. We will, without any question, have to become a very prominent political body, coördinated, not varying and differing in our ideas, not a profession set apart, so that we can be exploited in groups instead of dealing with the problem as a profession. It would seem to me, in the adjustments that must follow, we as a profession shall be forming labor unions and aligning ourselves with other employees—and there is no use kidding ourselves that we are not employees when we accept from the fund, pay in units. It is immaterial whether we get it in units or a pay roll by the month on a salary basis, we shall be accepting our orders from the lay supervised controlling staff. I do not think any of us are fatuous enough to think that we can maintain professional control under our present conception of legislation. Then we will be forced into the position of using strikes in order to enforce our rights, and of fighting for our rights in the adjustment problems that will follow. A profession with an altruistic motive, faced with the inevitable necessity of walking out of charity institutions in order to bring boards of supervisors and county representatives into line to make available to us fees for this large group of people, the indigent, who are presumably also not receiving adequate care; or at least of bringing about an adjustment whereby we as professional men may share with the community some of the financial responsibility or allow them to share with us some of the financial responsibility for remuneration for professional care.

I am of the opinion that it is good medicine sometimes not to operate, if your operation is going to kill the patient or make him really worse; and I am frank to say that I have approached this problem with a good deal of humility, without preconceived ideas, and I have attempted throughout this entire study to wait and see if some good could not come out of it. I myself am fundamentally not a "defeatist." I believe that we have the courage to stand up for our rights. I think we cannot compromise medicine for political expediency here today as to what we conceive to be the best interests of the people in order to meet an apparent demand, and even if we get compulsory health legislation forced upon us by the people, we are in a stronger position when we get through if we stand by the principle that we believe that individual service by the physician is the only safety of the welfare of the people. And today I hope that you gentlemen will have the courage to insist and stand together for witndrawing the hastily conceived, improperly presented plan, not based upon factual data but based entirely upon theory, and based upon a precedent that has proved to be an unhappy experience in every country in which it is being tried, where the medical profession has been degenerated into living conditions under which they render their work that is intolerable

to us. I do not believe the profession in this State, assuming the responsibility of being chosen as the weakest line in defense in national concepts, are going to fail in their duty to support the profession throughout the United States in standing for our principles rather than being subjected to exploitation.

The committee report recommended that a plan be made available that can use any mechanism that might be selected: it is immaterial to most of us whether it is a copartnership, a limited insurance company, a trust-fund mechanism, or any other mechanism that might be selected through a proper study by legal counsel. It is immaterial whether the plan actually receives a large support by voluntary contributions or not, because we as a profession will continue to take care of the people as they present themselves to us for care, and we do not need to worry as to legislation at times when the factors are decidedly against the best interests of the people, and there is an element of hysteria on the subject of social legislation. The plan was presented, not with the thought that it would be an overwhelming success. It was presented with the thought that we would have a mechanism available representing the profession that would, through organization, render or make available the services that we as individuals have been giving for centuries, and will continue to supply for centuries.

So I must heartily endorse and ask you to support the committee's recommendation that we do not go in for compulsory insurance. Also that we have available a mechanism that will, through organization, make care possible. If the national concepts of social adjustments develop along the lines on which they now seem to be unfolding, and we have some federal intervention with State legislation which will recognize the profession as a group, we shall be able to more fully declare our rights than will be possible under our present legislative set-up.

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Remarks by C. A. Broaddus, M.D.
Stockton

Mr. Speaker and Members of the House of Delegates:

. . . A lot has been said about the people's free choice of a doctor. I think they should have that free choice; but the people are not so concerned as to who the doctor is, so long as they get him for nothing. When I first came into San Joaquin County some ten years ago, the most talked-of man, the most outstanding surgeon, the one in whom the majority of people had confidence, the one for whom they would have lain down on the table and let him cut off their heads (if he said that was the important thing to do), was the medical superintendent of our County Hospital, and they got his services for nothing, as far as they could figure it out. That man has continued to have that reputation, and he has it today out at the County Hospital; but he tried to move into town and open a private office. He did not cut loose from his County Hospital salary of $7,500 a year, while first waiting to see if he could succeed as a private physician. The competition in private work has not been very serious in Stockton from this man, although he has a wonderful reputation because he worked for nothing out in the County Hospital. The County Hospital is still the most sought-for hospital in our county. Statistics show that 82 per cent of the people who want to go to a hospital go to our County Hospital because they get the service for nothing. We made a study for about a year trying to get somewhere. We got statistics and we showed them to our medical society, and there never had been a time in the history of that society when so close to 100 per cent of all of our medical profession were behind that investigation, as long as those seven members of the county society committee were carrying the responsibility and the reputation for putting it over. There came a time when we felt that we should withdraw all support from our County Hospital, and we got up a resolution, which we signed, saying that we would stand as one to withdraw. Now, believe it or not, some five doctors, with the support of the supervisors and the people behind them, absolutely blocked that. The following year, at the election of officers, we put a young man in as president of the society, and I am honest when I tell you today that I do not know what happened; but the committee was discharged, a new committee was appointed, which was highly in sympathy with the County Hospital, the whole thing died and nothing more was said except by the medical superintendent of our County Hospital, who declared that he had killed the whole thing and that they did not dare even open their mouths any more.

One of the speakers yesterday said that he did not know where the idea was coming from that there was a request for this kind of insurance on the part of the doctors. I cannot understand where he has been all of this time. Perhaps he has been practicing in the city. Perhaps he has been away. Our report, a copy of which is here submitted, says that at least 30 per cent of our population is agricultural. I think that in San Joaquin County, Kern County, and those other counties in that great agricultural valley, the proportion of farm people must be very much greater, because we certainly feel the pressure, we feel the demand, and it is not a demand for an insurance plan. It is a demand for an open County Hospital, with free service; let the physicians find out how they are going to get paid! . . . Without going into any more great details, it seems to me that the crux of the whole situation resolves itself in a statement which I have written out here for myself: That the most important action necessary for this House of Delegates is to empower a representative committee to systematically coöperate with the Interim Committee, which is bound to propose some legislation which will not be in the nature of a voluntary insurance plan controlled by the organized medical profession. I do not feel that the resolution which is before the House is going to solve our situation. I do not believe that if we adopt that resolution it is going to take us to Sacramento to coöperate with the Interim Committee. I firmly believe that the thing that we must do is to coöperate with those people down there and help to back any law that they do pass, or we will have to take the bone that is thrown to us.

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Remarks by L. A. Packard, M.D.
Bakersfield

Mr. Speaker and Members of the House of Delegates:

I have heard a lot about Kern County while I have been sitting here, and I am very sorry to say that I have to admit it is all true, and probably more. Some of the things in connection with the situation in Kern County are very pertinent when it comes to the matter of health insurance. Someone mentioned yesterday that because we have a situation in Kern County which is as bad as it is or worse, that is no reason why the rest of the State should be driven into any hurried action; which is very true. However, the elements, the factors, which are connected with the Kern County situation have become so state-wide and lead out into so many branches that the Kern County situation is no longer a local situation. Two years ago, when the legislature convened there was organized in Kern County what was then called the Kern General Hospital Protective League. This was a political organization, designed to protect and further the interests of those individuals who were promoting the open county hospital. This hospital league has prospered greatly and received political favors. One year ago they went out into the State of California and organized a California County Hospital Protective League, and I assure you that the membership of this California County Hospital Protective League is powerful politically. You may have wondered, after hearing Doctor Yoell read the editorial which he offered you from the *Farm Bureau Magazine*, how a doctor in Kern County can make a living. It has been extremely difficult, and there is only one reason why many of the medical profession are still alive in Kern County, and that reason is insurance. Compensation insurance or health insurance. Kern County is very largely an in-

dustrial center. The oil industry employs many thousands of men. There is a wealth of compensation work in that field. In addition to the compensation work, we find there are numerous health organizations connected with corporations which are large employers of labor. I have no doubt that the proponents of the voluntary type of insurance will tell you that these are types of voluntary insurance, but we do not look upon them as such. They have so many mandatory features that these same mandatory features remove them from the voluntary field. There is no answer to a county hospital situation with voluntary insurance. If you went into our county with a voluntary medical and hospital program which cost the individual $15 per year, and you attached a $20 bill to each and every receipt, you could not sell it for $15. The Kern County Medical Society has been in the throes of this situation for almost five years. They have made a more or less detailed study of this situation and the remedies, and last Thursday night the Kern County Society met and passed a resolution which the delegate was instructed to read and present to this House, showing the feeling of one society which has had experience with this situation. This resolution was passed unanimously. I am not going to bore you by reading the entire resolution. I shall read only the last paragraph:

"The Kern County Medical Society places itself on record as favoring compulsory health insurance, and urges the California Medical Association to lend its efforts, to the end that such legislation be as favorable as possible and that the California Medical Association shall not enter into any insurance business or involve any of its members in any insurance business of any kind or nature."

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Remarks by Rodney A. Yoell, M.D.
San Francisco

SPEECH NO. 2

Mr. Chairman and Members of the House of Delegates:

I arise to speak to you men today equally with the spirit of humility expressed by Doctor Kilgore. But this sense of humility that I feel, in discussing this problem, is the humility that one should feel in the presence of some great manifestation of nature's power. Humility does not necessarily mean a fear. Humility may very well mean a full understanding of the subject under contemplation, and I think that when we have finished our deliberations today medicine will feel a sense of humility, but medicine will have a sense of understanding.

I arise to speak in the justification of a right and the vindication of a principle. I arise to speak in the justification of the right of people, whom we all admit have not the individual capacity to finance health protection, to do so collectively. I arise to justify their right to a coöperative purchase of that protection. And with equal vehemence, I also arise to the right, and will fight for the right of the private competitive effort in the practice of medicine, the right to partake and join in an independent profession. . . . There is no man who has stood on this floor today who had the temerity to advocate the policy of do nothing. In this resolution that we are discussing we find a very characteristic thing, stale in its oldness. We have the same old harlot of voluntary insurance, with all her cheap finery, with all her false allurements, walking down the dream streets of expectancy under an illusion of chastity, and what is that illusion of chastity?

The illusion of chastity is that she feels she can pass herself off on other people as something that she has not any claim to, namely, virtue. Voluntary insurance, in the universal experience of mankind, has always exemplified the principle of prostitution. And why do I use the word "prostitution"? It is the correct word here. Yes, prostitution in the true sense of the word. Because the people who serve do not get their deserts, the people who pay are exploited, and usually the whole thing is a true perversion of principles, because under any system of voluntary insurance the thrifty stay in, the laggards do not come in. Those who are sick come in and when treated move out, and the stable members must pay. With such a plan you always are operating under a principle of adverse selection, which is false, misapplied, prostituted economics.

Voluntary insurance in this State is not a new thing. In the city by the Golden Gate we have two institutions which for over seventy years have operated so-called voluntary insurance plans. . . .

We have heard the question raised here that we should not indulge in theoretical debate. All right, let us agree. We are confronted here with facts, gentlemen, not theories, and I am going to show the facts. It is from these facts, and these facts only, that reasons can be adduced leading to the conclusions that we must accept the principle of compulsory health insurance as an answer to the problem, instead of voluntary insurance.

I am not arguing for a specific bill. Under the mandates of your House of Delegates, I had the honor to work on the Committee of Five, and to these men I pay my full need of respect. I have had drawn up a bill. That bill is not my bill, nor is it my plan. I have taken that bill from one end of the State to the other, submitting it to doctors, my own fellow practitioners, men like Catton, Ingber, Brooks, Porter, and others; and I have submitted it to a half-dozen other physicians; men in the city, men in the country, men in the small towns; from lawyers' offices, into the insurance companies, into industry and the railroads, in through the industries, in the fisheries, into the steel companies, up to the largest mining centers and back again, so that that bill represents the coördinated opinion of the best minds that we could get on the subject; but I will not argue for that bill. That is your question of privilege. I am merely arguing on the principle of mandatory insurance, because only under a system of mandatory insurance, developed under the right to the coöperative purchase of health protection, only under that system can we be free; otherwise State medicine is the inevitable alternative confronting us.

Now we hear a great deal from our adversaries, who charge us with excess of theory. Let me ask you this: Is this theory? Could the physicians of Kern County operate a voluntary insurance plan in Kern County under the present set-up? Is Doctor Packard here? I pause for a reply. Could you men of Kern County through your medical society, or otherwise, operate a voluntary insurance set-up in competition with the County Hospital?

Doctor Packard: Absolutely not.

Doctor Yoell: Now, remember that answer is a fact and not a theoretical argument.

Let us ask the men from San Joaquin County. Could they operate a voluntary insurance plan with any chance of success against the direct mandate of the people in the charter election authorizing the opening up to all non-indigents the use of the County Hospital? Doctor Powell, I pause for a reply.

Doctor Powell: I already answered, emphatically, no.

Doctor Yoell: Let me ask the man from Butte County, if he be here. A charter amendment is being submitted there in which it provides, according to Professor May of the University of California, that it be mandatory on the supervisors to hospitalize and give medical facilities and medical services to any citizen of the county, and transport him anywhere. Could you operate a system of voluntary insurance against a system of that kind?

Doctor Enloe: That is not passed yet. I do not know.

Doctor Yoell: Now, bearing those answers in mind, let us examine our opponent's theory against the facts. We hear a great deal about regimentation. That is a glorious word. It is like the old word "propaganda," an epithet according to who uses it; but it is a word that has been overused. Let us take the statement of these people who bring in comparisons between that which we want to do here and that which is being done in Europe. We are talking about insurance, and we are talking about the application of one of the greatest principles that belongs to any civilized coun-

try. Insurance is nothing new, but it is a civilized community's answer to a problem. Now, let me ask these men who oppose the idea of a mandatory system principle, and who accept the voluntary. Is there anything in Europe that separates their types of marine insurance from the type of marine insurance covering American ships? Is there anything in their personal liability insurance in Europe that differentiates that type of insurance from the type of liability insurance that exists in this country? No. Then, what is there in the peculiar nature of the application of the insurance principle against the hazard of illness that will work in Europe and will not work here? This is another challenging fact and not a theory, and I want facts and not theories in answer.

They talk about rugged individualism, they talk about stability of economic systems. They do not want the exercise of political power. How in God's world can we prevent it? If we do not pass the principle of mandatory insurance, and if it is passed by the people and we ignore the efforts that are being made, how much control can we expect from the county supervisors? Will medicine be able to instruct the board there? What sort of an arrangement would be made for our managing this thing? You men who have gone up against the supervisors in the various counties, as I have gone up, have you ever met with a coöperative spirit in the sense that they were willing to decide the mandate of the electorate, and refer it to what medicine knows is right and act on medicine's answer? Have you ever gone up before a lay group where the issue was what medicine considered right, and political or economic expediency dictated otherwise, and had medicine prevail? There is a fact and not a theory, and I want facts and not theories in your answer.

Now, what is there in this vaunted individuality? The individuality to suffer; the individuality to want; the individuality to feel sick; the individuality to die. There are 440,000 persons on relief in this very community today. Individuals! Individuals for what? To hold in their heart a want, an agony, and then to say that it is the duty of medicine to withhold from these people the one mechanism that the entire civilized experience of mankind has shown would remedy the situation. Is that the glory of our art? Is that the principle of our calling? Will this be our answer to the people of this great State? It was said yesterday that the great Morris Fishbein, the Eddie Cantor of medical economics, had expressed the opinion, that if anything should happen that was crack-brained and crazy, it would come out of California. Now, there was an insult. There was a fine comment on a people earnestly seeking the solution of a crying economic infamy.

Let us see the experience of one state society where they went to the fountainhead of wisdom, knowledge and fair dealing, as represented by the American Medical Association bureaucracy. I submit for your consideration a report from the Michigan State Medical Society that bears at its end the signature of its then secretary, Frederick Warnshuis, who is on our platform today. And I will recall to your minds that the progressive physicians of the great State of Michigan, cognizant of the economic problems and the economic drift of the times, went in humble obeisance and with a great spirit of humility to the temple of knowledge, to the gods on Parnassus in Chicago. Now, let us see how these men were received by these self-immortalized deities who hold unto themselves the fountainhead and source of imperial knowledge. They went and asked for certain information, and the report of their secretary back to the Michigan delegates was: [Reads from the Michigan report.] "To me the result of this meeting with our employees was both unsatisfactory and disturbing. Those present, in addition to the sick committee, were Dr. Bruce, Dr. West, Dr. Leland, Dr. Woodward and Dr. Carey, the ex-president of the American Medical Association. The Michigan delegates presented their problems before these men and asked for specific information. The information requested was not forthcoming, and the general attitude seemed antagonistic. While Doctor West kindly explained the workings of the American Medical Association, the discourse was not on the subject and failed to answer our questions. Doctor Leland appeared to be guarding 107 pages of manuscript on the subject of health insurance, but stated that he was not in a position to report. Doctor Carey magnanimously offered advice that seemed to be a bit gratuitous. He said that we should thoroughly thresh out the whole subject, that we should not involve ourselves, and that Michigan should delay lest it get into trouble. In short, the advice was, do nothing. Of course, all of this gave little information and less comfort to the Michigan Executive Committee that was present."

Now, here is a worse indictment. You can excuse people for doing nothing, but if people are informed and they have been officially requested to give information, and that information that is given out can be proven to be false, I care not whether it is in the American Medical Association, or otherwise, that is vicious and false, and deserves the utmost condemnation; and if we can get from this day's business a challenge to those men, that if we in California develop something that is not crazy and cracked-brained, but in the spirit of the pioneers that made this State, then I say, do it; but we will be honest, and it will not be built on the bottom of lies that have been emanating from Chicago sources of information. Article after article appearing week after week in the *Journal of the American Medical Association* was supposed to be by a British practitioner of medicine, a London leader; and when checked up (by these men who had to go to England to get their information, and not in their own organizations), when they got to England they found out that the preparation of the weekly letter had been placed in the hands of one who was not in general practice. Neither was he a member of the British Medical Association, or was there any record found of his having been at any time in the past thirty-three years. Then they took a publication in the *Journal of the American Medical Association* of a letter from a very distinguished Englishman, Sir Henry Brackenberry, an international authority on the subject of health insurance, and when they showed him this presumed copy of his letter this man made the statement that there was fraud, chicanery, deletion and distortion in the publication of his letter; that the salient points were left out, that interpolations were put in, and the whole purpose of the letter was so framed and so changed that it constituted an absolutely unwarranted attack on his true views. In other words, it was like taking the Bible and saying, "He went and fell amongst thieves; go thou and do likewise." I shall not bore you with the explanation that Sir Henry Brackenberry offered. I will say that the interpolated comments in the bulletin reports are unfair and misleading. This was an unworthy, detestably cheap type of attack.

Finally, after this very interesting experience, which was so graphically described for us over the signature of the member formerly of Michigan but present today, what was the resolution carried back officially to the Michigan directors: "Resolved, that in order to avert a repetition in the United States of the disturbing consequences that attended the adoption of health insurance in England, the House of Delegates shall appoint a committee to investigate and consider the policy of the Association toward health insurance, and present a report to the House of Delegates." In order to avert a repetition in the United States of the disturbing consequences attending the adoption of health insurance in England. In other words, medical men in England fought the law. They fought the inevitable in the tide of an economic storm in which they were caught. This thing moved with the impulse of an avalanche, and they failed to heed the warning; and the result is, that after twenty-five years, medicine stands today in England where we stand at the beginning of action if we but exercise our senses properly. Now, a stand that has to be taken in this country—and this is a fact—that we are apt to be met with successful legislative action by persons who neither know nor care for our problems. Here is the official journal

of the agricultural associations, the Pacific rural press, *The California Farmer*, and I merely quote because I do not wish to bore you; but this is factual, this is not theoretical; an editorial commenting on the health service, at an amazing low cost, furnished to Kern County. [Reads from paper.] "Here is the amazing story of what has eventuated. Ninety per cent of all hospital cases of the county now go to the County Hospital. A citizen may go to the hospital for medical treatment, for an operation, and even for dental treatment. The County Hospital also conducts the school nursing of the county. Thus, a complete health service is offered to the citizens. The cost is the amazing part. As a taxpayer, you help pay the costs of running the hospital, which amounts to an average of only $3 per capita per year. Almost unbelievable, is it not? If you, as an individual citizen, go to the hospital, you will find an even more amazing cost to yourself; but if you can pay, the total charge to you is only $3 per day as long as you are there. And so rural folks and city folks of Kern County, a large percentage of them, get their health service at cost, which is almost unbelievably low; and unless the upper courts sustain the Medical Association, this will endure."

Now, I submit this publication in evidence. [Hands copy to secretary.] I submit the report of the Canadian Medical Association, which endorses the principle of compulsory health insurance. [Hands copy to secretary.] I submit the report of the British Columbia Commission, which endorses compulsory health insurance. [Hands copy to secretary.] I submit the report of the British Medical Association, asking for a further extension and endorsing the principle of health insurance. [Hands copy to secretary.] And to show you that the legislative mind recognizes the inevitable trend in this country, I submit that four, and possibly five, counties in this State are proposing charter amendments opening up county hospitals to anyone. They are being written in the legal department of the University of California and in the department of political science. I point out also, in this connection, a letter from Senator Tickle, a distinguished member of the Interim Committee, and a sincere friend of medicine, which reads:

"Thanks for your very fine letter of June 8th, and the set-up you have outlined certainly coincides with my thoughts precisely. In view of the President's message to Congress, I am sure you fully appreciate the necessity of presenting a definite plan of health insurance at the next session of the legislature, for, failing this, I am rather fearful that the national government will tie health insurance on the tail of the kite of unemployment insurance, which I know you agree is something we do not wish.

"In fact, a study of the President's message rather convinces me that California should lead the way with a sound policy, and thus become the criterion of the nation. We can then turn our attention to unemployment insurance as something separate and apart from the cost of sickness. I feel you will also agree with me that in this way we can protect the medical fraternity and place them in their rightful position, and preserve them full integrity unto themselves.

"On account of pressing matters that needed my attention in this district, I had to hurry back from San Francisco last week, and regret I did not have sufficient time to see you. I shall do so, however, at the earliest possible moment, and in the meantime my every good wish is yours.

"Sincerely,

"Edward H. Tickle."

This shows our legislators are informed and possess a keen understanding of our position in the picture.

And on May 29, after your Committee of Five was appointed, came another letter from Senator Tickle:

"My congratulations upon your selection to committee. I am sure you will contribute generously to the sum total of intelligence expended upon this concrete problem. Personally, I was hoping that the group would be authorized to present a plan instead of a survey and findings. Thank Heaven, you are familiar with the tomes of literature available on this subject. I trust your committee will hold a meeting at Del Monte, where I may join you in the near future.

"With every good wish, I am sincerely yours,

"Edward H. Tickle."

Let me call to your attention that there has been brought out at this convention, by several speakers of the opposition, particularly Doctor Wilson, the statement that probably we can defeat a proposed federal compulsory health insurance bill, should one be offered—which they doubt. They suggest they can merge or change such a bill into some voluntary plan, claiming that because certain bankers, manufacturers and industrialist groups are in opposition to the administration's social security plans, we can well join with them in opposition.

In other words, if there is a chance of defeating the administration, in conjunction with certain anti-Roosevelt opportunists, we might be successful in putting over a plan of voluntary insurance. This is futilely fatuous. The only majority defeat the Administration has so far received in the national Congress was with the labor bill. Wagner is the spokesman for the labor group. Labor demands his bill, and Wagner gives it to them. Can we face opposition like that and expect to beat it with childish plans of medically operated piddling voluntary insurance schemes? Is that a theory or is that a fact?

Is it a theory or is it a fact that your Committee of Five was asked to draw a plan and present a bill which might be available for the 1935 session of the California Legislature? I ask, what is the plan? Is it this so-called voluntary plan, badly conceived and hastily drawn, offered by Doctor Kilgore? This voluntary plan, specifically? [Holds out copy of proposal for voluntary insurance sent to members of the House of Delegates.] Then what of the bill ordered to go with it? Do we find any such? No!

Is it a bill that he thought we might get through the legislature certain types of insurance laws which would permit us to function as he suggests? Could we get this legislation through now, even if we would? Is this a fact or a theory? The same general type of plan was proposed in substance several years ago, and our counsel, Mr. Hartley Peart, rejected it at that time as being illegal in conception and incapable of legal consummation. And in order to fix it so it could function he had to draw up a bastard plan that would admit that corporations could practice medicine; and in order for it to exist legally it should include 55 per cent of the chiropractors, naturopaths, osteopaths, and all the rest of the licentiates that practice any branch of the so-called healing art.

Leading where? I say it is leading nowhere! It is a false phantasy to think that we can go ahead and plan to block a tide as irresistible as the rise and fall of the tides of the sea. Is this a fact or is this a theory?

Now, we hear a great deal about political control under a voluntary plan. I submit this: Other speakers will show the futility of the voluntary plan, but I again submit this, that regulated political control, with a fixed position of medical representation in the law, is an infinitely better situation for the profession than open conscienceless commercial competition in a chaotic field without regulation. While it is perfectly true we might be free from the regularly constituted politician, would we be free from the equally constituted medical politician, the chiseler within our ranks who, like the deserter hanging around the flank of a retreating army, is ready to cut the throats of the wounded for gain? Do they guarantee under the voluntary plan that, with an open panel, they can operate against a system working with a closed panel? This has been borne out acutely today before this organization in this very city. This local society has considered at great length the possibility of trying to operate a voluntary plan to protect itself against a certain going organization operating now in this great city. They have been in the offices of attorneys seeking counsel, and what has been the answer? Legally, you have no redress. You can do nothing along these lines. Now, then, up to yesterday noon no legal plan was presented with a single shred or iota of good legal opinion behind it supporting the vague plans of voluntary insurance presented by Doctor Wilson's group, because they have drawn no bill capable of forming a basis for any such sound legal opinion favorable to this plan. The only opinion expressed against the constitutionality of a compulsory act passed by the legislature is that possibly it would be safer and more desirable that the constitution should be amended and thus prevent constant legislative amendations and changes. By having an initiative, or by a constitutional amendment, a compulsory act would be safer. I have file

after file from competent attorneys, some of the ablest legal minds in this State, who have fully briefed for four months this question, and it is the opinion of several men that the legislature can pass such an act. It is the opinion of some other of these men that this act should be supported by a constitutional amendment, but it is not necessary to have the constitutional amendment before the legislature acts; and if the legislature acts, and acts adversely by passing some bill unjust to us, then we have to test the constitutionality of it in a court, with a public mind against us and years of litigation before we could be free. Now, there is a fact, and not a theory.

In summary, I hold no brief for any particular plan, but I do fight for justification of the right of the public to collectively purchase health protection and the vindication of the right of competitive effort in medical practice. And I say further, and most emphatically, that if we doctors have a legally constituted position in the law, if we can have a group of men selected by the board of regents of the University of California, and the foresight to realize that there would be sane, decent laymen on the governing board or authority, and that licensed medical men could also act on it—but not *per se* as representatives of the California Medical Association—I say with such a set-up, medicine in California should be able to secure two men: licensed men, drawn from its own ranks, who, impressed with our own ideals and a loyalty to the public and their profession, could occupy such positions with the utmost fairness. I say the challenge of Doctor Kilgore is incorrect, that under such a plan the dishonest doctor, the chiseling physician, the malingerer, and the cheat would ultimately succeed. That is not my opinion of my profession. Medicine can and will serve, and can and will serve justly.

Now what is the proposition they present? The opposition asks us to underwrite the risk of the care of the people of California—that we be morally responsible; scientifically responsible, legally responsible, financially responsible. They ask too much. They ask that the sacrificial christ of medicine be laid upon the cross of conscienceless commercial competition, and that the ever-attendant rabble be permitted to gather about the foot of that cross, and divide up his garments.

They shall not take this State, this State and these people that we love so well—this State from out whose soil some of us spring, and upon the bounty of whose soil others have come to live and whom we all regard and love almost as one regards and loves a mother; they shall not say to our people we, and we alone, stand in opposition to the one thing so sorely needed by 77 per cent of these people.

Shall it be the attitude of organized medicine (which will be published throughout the length and breadth of the land) that after eight months of study, after the expenditure of over $86,000, and after the full coöperation and recommendations of the best intelligences drawn from the great universities of this State, that medicine shirks her honor and refuses to do the sane, the essential, the decent, the kindly, the civilized thing.

Oh, ye men of medicine, if I could but give to you the clarity of vision to see this thing as some of us see it! God forbid that we who see it thus should fail, unconvincing in our trial. If you who in the darkest watches of the night hear the first feeble cry of the newborn child, if you who watch all too often the tremulous closing of the eyelids of the dying, if you who see all these things in their full significance could equally see the issue as it lies within the future, forecast—what should our answer be, negation or acquiescence?

* * *

Remarks by John C. Ruddock, M.D.
Los Angeles

Mr. Speaker and Members of the House of Delegates:

I am proud to be a doctor. I am proud of the things that the word "doctor" stands for, and has stood for the past one hundred years. I am proud, also, of the American Medical Association, in spite of some of the remarks of previous speakers, because that Association stood up and announced itself as definitely opposed to those things tending to undermine the practice of medicine for the past century. Because of a depression that has affected the economics of every phase of our social existence, we find ourselves in the predicament of attempting to solve an economic problem.

I do not believe that there is the crying need which social workers, the Rosenwald fund, the Twentieth Century Fund, and other organized social uplifters are seeking to make us believe. They give large figures which would make us think that one-half of the population is crying for medical attention, and are suffering because they are not obtaining it. I have seen no figures which tell us how many people have been sick and have been unable to get attention. We know that only 10 per cent of our population is ill at one time, unless there is an epidemic, and in such an extremity the medical profession always has, will now, and always will offer their services, and see that none are unprovided for.

I challenge Doctor Yoell to prove his statements that there is a crying need by the populace. He staggers us with figures and reports and excerpts from articles, but the average person does not know what it is all about.

And now we have met here to discuss whether we shall discard the staid and proved methods of practice of medicine, the individual relation of the patient to his doctor—certain ethical standards of practice for a hypothetical, unproved medical practice that has not been successful in its various forms already tried in several foreign countries.

I believe in the insurance principle, and such a principle can be applied to the practice of medicine without jeopardizing the ideals of which we are all proud. However, you must admit that you cannot sell service, or put service on a monetary basis. There is not one of you who gives the same service, or a service of equal value to a patient. There is not one of you who has the same personality, and that is part of the thing that you are offering for a paid premium. It would be a simple matter to let a man buy insurance where he will, and give him cash sick benefits, and let him pay his doctor, whoever he may be, in the same manner in which he does it now. Why should the doctor keep shouldering the burden of the poor in the community, when it is a community problem, and not the doctor's problem alone. He should be concerned only with medical service and good medical service.

The problems of food, shelter, and clothing are so intimately entwined in the problem of so-called medical economics that it is impossible to separate them.

This convention should be discussing ways and means to improve the standards of doctors, to protect the practice of medicine from the inroads of the cults, to stop the vicious fee splitting, the overcharging and the ambulance chasing, and to prevent other practices that bring disrepute upon our profession. Our voice, or our desire, will not change in any respect the economic readjustment that is now going on; but our voice, if raised in defense of staid and proven principles, will command the respect of all.

Let us not be led astray by a few persons, whom I believe are very sincere in what they think is right, and are attempting to be missionaries and convert the rest of us to their way of thinking, be it right or wrong.

* * *

Remarks by Theodore C. Lawson, M.D.
Oakland

Mr. Speaker and Members of the House of Delegates:

I come before you with an apology; in fact, with an humble apology. After we have listened to the very excellent, logical, level-headed presentation of the whole situation of medical insurance, as I see it, by Doctor Kilgore, and after listening to the very excellent presentation of the opposite side, and have listened to the heights of rhetoric with which the preceding speaker has favored us, and which I admire a great deal, I am afraid it is going to be a very disappointing anticlimax for you to listen to the few words that I have to say. I wish to represent the young, budding doctor as

nearly as I can, because my memory of the hospital days are not so far past, and I have an appreciation for some of the problems that the young doctor has had to face in the past, and is facing at the present time. Osler has said that the three stages of medical practice can be divided into three practically equal parts; the first stage is, when one is earning and eating crusts of bread; the second stage when one can add a little butter and an occasional cake to it, and the third stage when one can enjoy a little bit of ale along with it. I am still in the stage of the crusts of bread. I have not been in practice ten years yet, and I feel that I represent an opinion of the majority of the younger men in the community of Alameda County. . . .

One of the speakers, Doctor Ruddock, yesterday brought up a point as to who is asking for a change in medical economics? What is the demand for a change? Is it possible for the young doctor to go out into practice with economic conditions as they are, granting that nothing is done? Just for the sake of argument, I say, *yes*. Very distinctly, yes, even in this time of depression; if he has a good medical knowledge, sincerity of purpose, a moral life and good salesmanship. Granting also that something may have to be done, just for the sake of argument, I feel that in spite of the 77 per cent of the people who, we are told in cold statistics, can not afford good medical treatment under present conditions, at the present time in our county we are taking care of every single person who wants good medical care, and doing it well. First, we are giving our time, for the charity patients in our county hospitals, and I, among others, am glad to give my share of time freely. Every medical man in Alameda County is giving a share of his time. Secondly, the entire Alameda County Association has gone on record to be willing to take their turn in caring for part-pay patients who are not charity cases and yet who cannot pay the usual fees. These fees are regulated by the social service, according to their ability to pay. The third group represents those who can come into our private offices and pay the usual fee, and they are well taken care of. Of course, I merely agree here for the sake of argument that this does not apply to the entire State, and as a gentleman from Sacramento very well said yesterday, each county probably can take care of its own problem, if we will do nothing and make no changes. Again, coming back to the question, Who is doing all of this talking? My patients are not talking so much about it. Probably I am a young, what my friends might say, a young mossback. If I am, I want to know where I got off on a tangent, because I am very sincere in by beliefs, and I am talking for the younger practitioners at the present time. I feel sincerely that a part of it is being brought up before the public time and time again by the laymen who have no business with it, except that it has become a racket. I won't say that this is my personal opinion, and state it in such bald terms, but I will state that these lay organizations that are continually hounding us on this subject are making more or less a racket of it, and we, the medical profession, are the goats and the victims of it. I want to say that the majority of patients that come into my office are quite satisfied with things as they are. For the last year in Alameda County we have had the proposition of a voluntary hospital insurance plan, and I will venture to say that the majority of my patients would enter into it, if it were properly explained to them. I will agree with you that that represents a certain class of people only in a certain economic status; but I feel, in view of what Doctor Kilgore has mentioned about the voluntary plan started in Seattle, in view of my personal associations, and in talking with patients (my own and others), that it will work to a very satisfactory degree, at least until we see where we are, and until we get our foundations built for this superstructure which we hope to build.

Now, as to the compulsory plan. Personally, I feel it does not make any difference if we write in the bill at the present time that the medical profession shall have entire control, or whether the State Legislature writes its own bill. I agree with Doctor Kilgore's statement that the medical profession will eventually have no more say about it than the profession has in the British system. Again, I shall not feel so bad if a compulsory system comes so far as we physicians are concerned. We shall still make a living. I shall feel sincerely sorry for the patient, because this is what is going to happen, as sure as God made little apples, maybe not in five years after the compulsory system has been put into effect, maybe not in ten years; but maybe after our boys are practicing medicine, the following picture will be duplicated in the United States: A doctor went over to England to see a friend of his, who was a panel doctor, and being a sociable gentleman, he took his American friend out for a three days' outing. On their return there were thirty-eight patients in the panel physicians' office, and this is what the English doctor did: "All those having a cough, stand up." A stereotyped cough prescription was given to all of those who stood. "Anybody having a headache or pain, stand up." A few more stood up. Another already prepared prescription was given to them. And in a few minutes, probably not an hour, he summarized the rest of the cases that didn't have a cough or pain or headache, and he was through. I feel sorry for the patients. This will be an entering wedge toward State Medicine. That is all that is necessary. More and more regulations will be given, and more and more amendments will be put on. It will be a bill which will make it harder for the medical profession as we go along. The very fact that you gentlemen are in the United States today shows that your forefathers at some time, if they didn't come to the United States before the Declaration of Independence, came at least at a subsequent time, because they did not care for any regimentation or being told what to do as individuals within certain limits, as they were forced to do in old Europe. I personally resent, as an American citizen, as I am sure you all do, in being told by laymen how we shall conduct our own affairs, and how we shall manage our own matters of medical practice. . . . I feel that any bill for medical insurance right now, at the present time, that is drawn up will not fit the conditions five or ten years hence.

Now, we are told with a great deal of gloom, with a great deal of pessimism, that if we do not do something here today, tomorrow the State Legislature will snap a bill on us before we realize what has happened. Just to clarify the situation, Mr. Chairman, in the minds of a good many delegates here, I would like to ask some member of the Council—probably Dr. Junius Harris could tell us better than anybody at the present time—if that is the case, why is that situation allowed to exist? To my mind the finest thing that could have happened to organized medicine in California was this last initiative fight that we had on chiro-naturopathic amendments No. 9 and No. 17. It showed to me the strength that we, as members of the California Medical Association, really have in this State if we go to work. Up there in Alameda County we sent out thousands of personal letters and post cards through the County Medical Association to our patients, and we should have sent out thousands more if everybody sent out as many letters as they could. Some of the men sent out four and five hundred of those letters. I am very proud to observe that I doubt if there is a county in this State where there is more coöperation, less bickering, and fewer factions than in our Alameda County Medical Association. All the members work together. And if medicine can do that, and we would coöperate individually in the counties, and in the State Medical Association, and put our shoulders to the wheel, I do not think that the legislature will do anything against our concerted wish. . . .

We point here to the fact that medical care is one of the necessities of life, as clothing, food and shelter. Does your man in the SERA go to the grocery store and buy groceries on credit? No. He pays for them. The Government takes care of that. Does he go and get his house or apartment rent free? No. Provision is made for that. Some of my colleagues say (this is not my personal view), why not the same thing about the medical care of the individual patient? If it is a necessity, why not put it under the same heading?

Why, again, is the medical profession the goat all the time of these lay propagandists that keep talking about this all the time until you are nauseated with it? These lay organizations have as much right in dictating to us as to how we should conduct our business as one of us would have in telling the chief engineer of the San Francisco-Oakland Bay Bridge how to erect his piers, or the Big Six Companies how to construct the Boulder Dam. My father taught me to be respectful of age and experience. Age and experience in the form of the majority report of our Committee of Five have voted in favor of a voluntary insurance plan and against the compulsory plan. Age and experience in the form of the report of Reference Committee No. 1, to which this subject was referred by our speaker, have voted for the adoption of the voluntary insurance plan and against the compulsory plan. Gentlemen, in behalf of the younger members of our noble profession, I desire to state that we wish to be thus guided by the age and experience as represented by these two committees that have discharged their duties so ably. . . . It is our business to be interested in these problems. We are interested. We feel that these are our problems. We are one of the most charitable of all the professions. We will take care of the poor. We will even take care of the improvident, but we ask that we be permitted to do it in our own, American way. Let us build solidly, erect first the foundation and raise the superstructure gradually, and then we will know what kind of roof to put over it.

* * *

Remarks by C. Max Anderson, M.D.
Hermosa Beach

Mr. Speaker and Members of the House of Delegates:

There are two social economic philosophies concerned here: one on the right, which is the American system, and another on the extreme left, which is represented especially in Europe. . . . I want to call to the attention of the delegates the fact that there is a possible other solution of the problem—a middle ground. I am going to name the possible solutions that I have in mind in the order of least importance; that is, in order of least satisfactory solution first. First, the voluntary plan of insurance as submitted by the Committee of Five. Second, the compulsory plan of insurance, as presented by that same committee. Third, masterful inaction. Fourth, the plan that I submitted in resolution, namely, limited mutual benefit insurance, the insurance payment being made in cash and not in service. The objections to the plans that have been produced by the Committee of Five have been well discussed. They have been brought out by both sides. . . .

Considering now the resolutions before the House, I see no way in which the objectionable interposition of a third party, between the patient and his doctor, can be overcome. This is a very serious objection. Most doctors and most patients do not want a third party, sitting in an office miles away, dictating as to how much, how little, or what kind of treatment is to be given in a given instance, as is now the practice in the industrial insurance field. Regimentation and subjugation of the doctor and the patient as well are inevitable in the schemes presented. Increased commercialization of medicine cannot be kept out of the picture. To my mind the suggestion of collective bargaining in the buying of professional service is exceedingly pernicious. It simply means that the lowest bidder would be the man that gets the business, and aggregations of capital would be coming to the individual doctor to get him to give the lowest bid possible, resulting in the cheapest service possible. Then we have the political objections. I think none here are so naïve as to believe they are not very real.

I must very seriously object to the voluntary plan as putting the medical profession in the insurance business. Why, if the big insurance companies fear to go into this type of insurance, and will not enter this field, should we of the medical profession, with our lack of experience, enter the field? . . . I ask you to accept real insurance on a real insurance basis through limited mutual benefit insurance.

THE LURE OF MEDICAL HISTORY*

THE LOS ANGELES MEDICAL ASSOCIATION LIBRARY†

By Chauncey D. Leake, Ph.D.
San Francisco

ENVIOUS societies of your colleagues elsewhere join in congratulating you on the splendidly designed and equipped library you are opening tonight to facilitate the advance of your professional activities in these beautiful meeting rooms. It is a great honor for me to have been asked to be with you. It is due to the amazing communication and transportation systems at present at our convenience that I can be with you. Ten days ago a telegram from Doctor Belt roused me from the dull surroundings of a lounge-car in El Paso, Texas. How it reached me there, I cannot fathom. Today I lectured, as is my job, to some dentists in San Francisco at 8 a. m., then to some chemists in Berkeley at 11 a. m., and now now this evening, after a delightful dinner, I am about to talk with some bibliophiles in Los Angeles, some four hundred miles from where I was this afternoon. When your library was conceived scarcely a generation ago, this would have all been impossible.

AN EARLY LIBRARY EFFORT BY THE ASSOCIATION

In the minutes of the Los Angeles Medical Association meeting of December 19, 1890, an inquisitive searcher, such as Dr. John Shuman, may read:

"The library committee reported that they had secured two dozen chairs, in addition to those previously reported on; also a chair for the president, and a new desk, and a seal for the society's use. The committee also reported that they had written a circular letter to publishers of all of the known journals of medicine published in the United States, numbering something over two hundred, requesting them to send their respective journals (gratuitously) to the library of the Los Angeles County Medical Association. The present administration assured us that the library is soon to be constructed."

Now, after forty-four years, and through the help of your friends, through the magnanimity of the Barlow Medical Library Association, and through your own fine spirit and coöperative enthusiasm, you have your own library building to house your precious books, some gratuitously enough received no doubt, and some secured by downright purchase and sometimes sacrifice. Maybe some small ones just appeared on your shelves, begotten in that delightful bookish way so whimsically and cleverly described in his address of dedication in 1926 at the Allen Memorial Medical Library of Cleveland by that eminent obstetrician, Harvey Cushing, who has brought forth so many grand ideas.

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany Department, and its page number will be found on the front cover.

† An address at the formal opening of the library of the Los Angeles County Medical Association, November 27, 1934.

A PARADOX OF GROWTH WITH MATURITY

Anyway, your library has grown as your society has grown, and you have both probably endured the same sort of growing pains. The analogy between an individual and a medical society or medical library does not hold beyond this adolescent period, for your society and library are now mature, but paradoxically still growing and developing, as will happen as long as they continue to serve a useful and worthy purpose. It is an unfailing mark of maturity for a medical library when it reaches the dignity indicated by the stiff shirts here this evening. You may now permit the queen of your guardian angels to become your gadfly, to be sure that neither of you, your Association nor your library become in any way stiff behind the dignity of your present garments, or that you become senile, decrepit, atrophic, or sclerotic by any lack of ability on your part to live wholesomely, generously and cleanly, as all things medical should live. Lest either of you ever have a tendency, during the long, long life of useful and joyful activity your friends are all wishing for you, to become haughty, arrogant, smug, or ungenerous, let it be hoped that some one of these friends may do you the real kindness of gently and occasionally reminding you of your adolescence. To all of us this is a reminder frequently as embarrassing as a baby picture, but often helpful in promoting that tolerant humility and honest modesty so characteristic of good books as well as of good men.

You have, I know, forgiven my presumption in showing you the baby picture of this now stately and great library. I hope you will be just as forgiving if I further presume to show you the companion picture of your great and growing society. It was also unearthed from the minutes of your society in the late seventies, which show "such lethargy that a meeting was held at the home of the secretary and a resolution passed declaring the office of president vacant for non-attendance." The next year there was but one meeting of the society and no officers were elected, the answers at roll call being too few. But that was before Iowa migrated, before a commercial use displaced a gentler medicinal one for the black smelly slime oozing from Rancho La Brera and Signal Hill, and also before movie stars fell on the city of the Queen of the Angels.

BENEFACTORS WHO HELPED MAKE YOUR PRESENT LIBRARY POSSIBLE

This evening's exercises are really a testimonial to all those valiant ones who struggled so long and hard to make your present society and library what they now are: the late Doctors W. Hendryx and F. A. Seymour, who with others first had the vision of a library for you some fifty years ago; Dr. Milbank Johnson, who as a faculty member of the then College of Medicine of the University of Southern California, really started the book-giving which created your collection and who was your first real librarian; Dr. Walter Jarvis Barlow, your most helpful patron, who so generously gave a $30,000 building and volumes in 1907 which were administered for your benefit by the Barlow Medical Library Association, and whose modesty now in connection with the use of his name you must not forget when "ripening time" suggests renaming your library or reading room; the Los Angeles Medical Department of the University of California, which in the passing years gave more than $10,000; Dr. Harlan Shoemaker, whose efforts to create a headquarters building fund have been rewarded by these noble buildings; the late Dr. Theodore Lyster; your present enthusiastic committee, headed by the distinguished book lover and medical historian, the clinician, George Dock, Dr. Elmer Belt, and Dr. H. E. Schiffbauer, and then your tireless librarians, past and present, and especially Mrs. Mary Irish, who has moved you here. What responsibilities rest on you, who are following, to justify the trust reposed in you by these who go before you! and what joy will be yours as that trust is well administered! Now that you have so nobly executed what visions your leaders have had of what a medical library should be, you have the pleasant obligation of preserving appropriate remembrance of them. And where more fittingly than in your library?

THE MEDICAL HISTORY OF CALIFORNIA

The medical history of California has been delightfully sketched by Dr. George Lyman, Dr. Adelaide Brown, Miss Louise Ophüls, Dr. George H. Kress, and others, in the historical symposium in the May, 1925, issue of California and Western Medicine, in the *History of the Medical Profession of Southern California*, a volume brought off the press by Dr. George H. Kress in 1910, in Dr. John Shuman's account of medicine in Southern California, which was published in 1930 in the *Medical Journal and Record*, and especially in the brilliantly written and beautifully printed *California's Medical Story* by Dr. Henry Harris. As the interested physician goes over this material, he finds much in it to excite his curiosity and to stimulate him to discover more about the remarkable individuals who first brought rational medicine to the last great frontier, and about the extraordinary situations in which they often found themselves. Thus, Dr. George Lyman enjoyed himself immensely and contributed to the interest of us all by his study of the character and adventures of John Marsh, who got a license to practice medicine in California by showing a Latin bachelor's diploma from Harvard to the authorities of Los Angeles. He also got started on a fine story in searching out the grave-stone of Dr. Felix P. Wierzbicki, the liberty- and truth-loving Pole, who wrote the first book to be printed in English in California—*California as It Is and as It May Be, or a Guide to the Gold Region*, San Francisco, 1849—a book which revealed, incidentally, more truth than poetry about the newly opened country.

What thrills there are yet to be discovered by that medical Californiac who will investigate the medical practices of the California aborigenes! What a story might be reconstructed from the experiences of the surgeons who accompanied the sixteenth and seventeenth century exploring ex-

peditions of the Spanish, English, and Russians, the tentacles of whose empires were creeping out to reach a hold for the domination of the Pacific! Who was Dr. James Wood, surgeon to Francis Drake on the great privateering voyage around the globe, who performed the first postmortem examination in California in 1578, and died himself four days later? What are the details of the life of Dr. Pedro Prat, who ministered to the first Spanish colonists in California (1769-1773) and of whom Doctor Lyman says, "The sword, the cross, and the scalpel proceeded hand in hand, and had it not been for the presence of Pedro Prat, it is probable that the projected province would have miscarried and never withstood the travail of its birth." What of the career of the Spanish Surgeon-General, Dr. Pablo Soler, who was called the "Beloved Physician" by the grateful colonists during his period from 1792 to 1800, or of Dr. Manuel Quixano, the last of the Spanish Surgeon-Generals (1807-1824), whose medical instruments and effects Doctor Lyman found still in Monterey? Why not investigate the lives and works of the surgeon-generals of California under the Mexican régime (1824-1847) when American influence, such as reflected in the names of Edward Turner Bale, Richard Somerset Den, and John Marsh, was beginning to be felt? And then what romance and excitement are to be found in collecting data on the wild American physicians who added so much to the color of the Gold Rush and Vigilante periods! We all recall Gibbons, Cooper, Lane, Toland, Logan, Cole, who struggled like Titans in the North to found rival schools still surviving, and Osborn, Widney, Cullen, Orme, Lindley, MacGowan, Moore, Ellis, and others, who could work together more amicably in the gentler South.

For the treasures of story locked in such names, Doctors Lyman, Kress, Eloesser, Dock, Shuman, and Harris, have found a key. It is an easy one to use, and now with this splendid repository for such wealth, some of you must use it and bring your spoils here where they may be gloated over. It is only necessary for some of you to be curious, and then to look about a little on the slender clues you have; and you will be amazed at what you can find.

CALIFORNIA CONTRIBUTORS TO MEDICAL ADVANCEMENT

It is remarkable how many great contributors to medicine have been ripened by California sunshine. One may think of Dr. James Blake (1814-1893), who first showed a relation between the chemical constitution of a drug and its physiological action on the body, who first proved that the best treatment for tuberculosis is rest in the open air, and who was as zealous a scientist as any Arrowsmith; Dr. F. F. Fehleisen (1854-1924), discoverer of the bacterial etiology of erysipelas, who seems to have fled to the tolerant haven of California after making the political indiscretion of suggesting that the recent Kaiser's father might have had a syphilitic laryngitis; Jacques Loeb (1859-1924), the great mechanistic physiologist, and his brilliant Australian pupil, T. Brailsford Robertson (1884-1932); the noted pathologist, William Ophüls (1871-1933); the native sons, George H. F. Nuttall, one of the founders of modern parasitology, Joseph Erlanger, physiologist, Arthur Hirschfelder, pharmacologist and cardiologist, Herbert Evans, anatomist, Walter Alvarez, clinician; the Nobel prize winners, Thomas Hunt Morgan and George Whipple; and he whose spirit would rejoice in this evening's festivities, LeRoy Crummer (1872-1934), one of the greatest of medical bibliophiles.

Dr. Charles Singer, the outstanding English authority on the history of medicine and science, who graced the faculty of the University of California for a brief two years, has indicated, in his preface to Doctor Harris' *California's Medical Story,* that unusual opportunities exist in our State for the study and recording of an extraordinary medical development. We must not neglect the fleeting and perishable records of the recent years, or indeed of the present. Newspaper clippings, magazine articles, reprints, manuscripts, proofs of papers, programs of meetings, pictures—all these readily forgotten items form often the priceless possessions of libraries in times to come.

In the exhibit room of your library it is easy to visualize the permanent display you will make of material relating to California medicine: a case devoted to aboriginal medical practices; another relating to the Spanish period, from 1760 to 1824; a third, containing items from the Mexican régime from 1824 to 1847; a fourth, showing the American Gold Rush influence, and then one expanding case for your treasures from the more recent years. Significantly, after its unpleasant experience with the plague at the beginning of this century, California has pioneered in public health protection not only for the State, but for the nation; as witness its work in influenza, plague, poliomyelitis, psittacosis, and amebiasis. The records of these efforts can nowhere be better kept than in your library, close to where much of this public spirit has arisen.

MEDICAL LITERATURE FROM ALL LANDS AND AUTHORS

But a medical library must have at heart also the preservation of copies of medical classics from all lands and authors. The current productiveness in medicine is chiefly recorded in periodicals. The medical library is sorely pressed these days with shrinking currency and mounting costs of medical journals, especially foreign ones. And what a plague the number has become! Your librarian can testify to what a miserable matter it is for the librarian to handle such a variety of physical format. Why cannot we agree and standardize our journal sizes and bibliographical notations? But individualism in periodicals and books, no less than in men, resists regimentation, even for the sake of greater convenience!

Of greater dignity, of course, are those substantial medical classics printed from the fifteenth to the nineteenth centuries, which have survived the wearing down of time through the solidity of their merit. These are hard to obtain; but such

a library as this must try to secure them. It is astonishing how rapidly they multiply, once a lusty pair have been given sanctuary and nesting space on your shelves. Try the experiment of placing a cuneiform medical tablet (if you can get one) alongside an autographed reprint of an article embodying some of Dr. George Dock's medical wisdom (also if you can get one) and I think you will be surprised to find how quickly the whole gorgeous cavalcade of medical history will hatch out between them. You are fortunate in having the Huntington Library close at hand, so that you may learn to use its unique resources now being explored medically by Dr. Sanford Larkey. You are also fortunate in having the advantage of such sound advice in the gathering of medical classics as can be given by Doctors Dock and Belt, and Mrs. Myrtle Ingraham. What joy you will have working with them in building up the historical collection you should have!

THE MOST STRIKING FEATURE OF BOOKS

The most striking feature of books to me is their impartial generosity. This is especially true of medical books, for the writers in that fraternity belong to what is essentially a generous profession. To anyone who looks into these books on your shelves will the information they contain be imparted, varying only in the looker's ability to comprehend. The majority of those worthy to be on your shelves will breathe a rich aroma of helpful knowledge, and sometimes a sharper tang of genuine inspiration. When brains are bred with books, the gestation of genius has begun. Let the generosity of your books give you the clue regarding their use.

In his dedicatory address for the Boston Medical Library, December 3, 1878, at a time when your society could not even elect officers for lack of attendance, Oliver Wendell Holmes pleaded for the widest hospitality for all kinds of books relating to medicine. However hospitable you may be to books, however well you may care for them, file them, and catalogue them, they will be useless in the true sense unless you do everything possible to encourage their use. You recall Harvey Cushing's injunction:

"Mead's library motto, *'Non sibi sed toti,'* might fittingly be adopted for the *ex libris* of our great medical libraries. For a library must make unselfish use of its possessions even at the risk of an occasional loss. An open shelf, like an open shop, encourages the real worker, who often chooses to browse for himself. A library unexercised, and which takes no chances in life, is susceptible to the deterioration and sclerosis certain to attend a poor circulation. To be sure, with some people there is no mine and thine in the matter of books; but one must take the chance and fill in the gaps when they occur, however painful, temporarily, the loss. It's far better than not to be used at all."

The State Medical Library, sponsored by the editor of CALIFORNIA AND WESTERN MEDICINE and with the support of the California Medical Association, was created in California some five years ago for the purpose of trying to improve the public health and medical facilities of California by making it possible for the rural practitioner, far removed from such a library as yours, to keep abreast of current medical advance through a circulating periodical system for the lending, for a few days each month, of specialty and foreign journals. The only cost so far to the individual physician has been postage. You are cordially invited to coöperate in this venture through the south of California by coördination with the State Medical Library, whereby you might secure periodicals for permanent deposit on your shelves, thus saving you some of the costs of subscribing to them, and whereby your monograph and reference material might be made available to those outlying physicians who may have need of it. Thus may your library follow the impartial generosity of your books. At any rate, may you always help it to do its part toward making the common health the common wealth.

IN CONCLUSION

May your great new library, then, always prosper! Surely it will, if but hospitality toward any book relating to medicine and generosity in its use may always remain your guiding principles of operation. Under such a spirit you cannot fail to nurture greatness; and to the library of the Los Angeles Medical Association, then, that greatness will be thankful.

University of California Medical School,

CLINICAL NOTES AND CASE REPORTS

RHINOSCLEROMA*

By E. M. BINGHAM, M.D.
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RHINOSCLEROMA is a moderately prevalent disease in central Europe, especially in Poland. In England and North America very few cases have been seen, although a fairly large number have been recognized in Central America. Approximately forty foreign-born individuals have been discovered to have the disease in the United States. Canfield [1] has recently reported the fifth case to be found in a native-born American.

H. E. Alderson,[2] of the Stanford University department of dermatology, has found two patients with rhinoscleroma in California. One of these he reported in 1914, the other in 1932. Another infection of this type has recently come to our attention.

REPORT OF CASE

C. F., a Mexican male of twenty-three years, was admitted to the Riverside County Hospital June 27, 1934. He complained of nasal obstruction, attacks of vertigo, and frequent headaches. He had been observed and expectant treatment given him in the nose and throat clinic of the out-patient department since January, and was sent in at this time for biopsy. He had had previous treatment in the same clinic in 1931, at which time a diagnosis of hypertrophic rhinitis was made.

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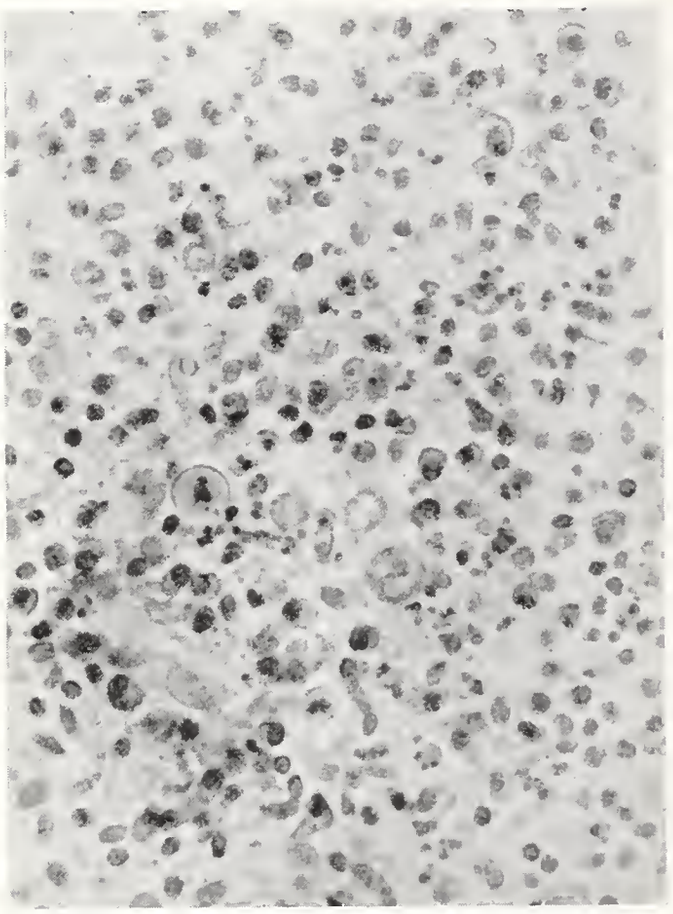


Fig. 1.—Rhinoscleroma. Microphotograph showing type of cellular reactions present. The two largest round objects are Mikulicz cells.

Past medical history was negative except for injury to nose when hit by a baseball in 1925. Apparently there was no fracture. He was born in Mexico and lived there until eight years old, residing in Riverside since that time. He had spent the months of August to December of the past four years in the Fresno district as a fruit picker. Two sisters, one brother, and parents were in good health.

General physical examination showed an apparently normal Mexican male. The nose showed hypertrophic changes of the turbinates, with obstruction of the nasal passages, more marked on the right. There were adhesions between the middle turbinates and the septum. The turbinates and adhesions were very firm and did not bleed readily.

Laboratory.—Normal urine; hemoglobin, 103 per cent; W. B. C., 7,400 with normal differential; blood Wassermann and Kahn, negative.

A small piece of tissue was removed from each side for microscopic section and the patient discharged June 29. When the pathological report was returned, he was called back to the hospital for further biopsies and cultures, being readmitted July 18. The following day there was moderate bleeding and he was not discharged until July 20.

The patient was seen in the out-patient department for approximately a month following surgery, when he again left for Fresno. He was given potassium iodid by mouth and sodium iodid (20 cubic centimeters, 10 per cent) intravenously three times a week. He did not tolerate iodids well, developing a very marked hoarseness. When last seen, he was subjectively improving and nasal obstruction had not recurred. He was instructed to continue taking the potassium iodid by mouth.

COMMENT

Rhinoscleroma is a chronic granuloma commonly involving the nose. The lesions frequently appear in other parts of the respiratory tract, including the larynx and trachea, and sometimes have spread to the skin. Because of the lack of confinement to the nose, it has been suggested that the name be simply "scleroma."

Besides the clinical findings, diagnosis is usually based on biopsy, although a complement fixation test has been used.

In the early stages of the disease the lesion presents only loose granulation tissue infiltrated with plasma cells and phagocytes. In such cases the diagnosis from sections alone may be difficult.[3]

After the disease is fully established, the recognition of it in the tissues is based on three criteria, all of which were found in tissue from our patient.

1. Large vacuolated phagocytic cells are present in the granulation tissue. Their nuclei are frequently pyknotic. These phagocytes are termed "Mikulicz cells."

2. A degeneration appears in the Mikulicz cells whereby hyalin material is formed.[4] The vacuoles in the Mikulicz cells enlarge and become eosinophilic. The nucleus becomes dark and compressed, and indented by the vacuoles about it. The vacuoles also produce bulges in the external outlines of the cells. Finally, the nucleus disappears, the cell-wall ruptures, and the spherical eosinophilic masses are seen in a loose clump in the tissue. They are commonly five to fifteen microns in diameter and are called "Unna bodies."

3. Gram-negative bacilli resembling Friedländer's pneumobacillus are found in the tissue. A large proportion of these are in the Mikulicz cells. The cultural characteristics of these organisms have been described by Figi and Thompson.[5]

In old lesions much dense and more or less hyalinized connective tissue is found. In this stage diagnosis by biopsy may be difficult, as Mikulicz cells and Unna bodies are often absent.

Except in the few instances in which more than one case has been found in a family, it has been very difficult to elicit any history of exposure to others who have the infection. The onset of the disease is insidious and prolonged. The disease is one which is usually found in the more illiterate classes.

SUMMARY

Three cases of rhinoscleroma have been found in California. The one which we are reporting appeared in a Mexican who has spent much of his life in Riverside.

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College of Medical Evangelists, Loma Linda.

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BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

GENITAL AND ANAL PRURITUS

ETIOLOGY OF PRURITUS ANI

H. J. Templeton, M. D. (3115 Webster Street, Oakland).—Pruritus ani may be caused by etiologic agents as obvious and as near to the anal canal as simple fissures, or as complex and remote as some neurosis or psychic fixation in the central nervous system. The difficulty of discovering the etiology may vary from the ease of recognition of pinworms to the complexities of a complete medical study in some of the more obscure cases.

Local causes are the easiest to discover, and obviously the first to approach. When the skin around the anus is pearly gray and sodden, suspect epidermophytosis. This diagnosis may be strengthened by finding a concurrent epidermophytosis of the toes and can be clinched by finding the fungi in scrapings. An irritating leukorrhea may be the cause of the pruritus; or, likewise, a diabetic urine. Fissures and external hemorrhoids are obviously possible trouble makers. Sometimes local infection, with such streptococci as the S. fecalis or other pathogens, may be causative; but it is difficult to prove this. Cultures, intradermal tests and appropriate vaccine therapy would seem to be in order in obstinate cases. A well-taken history will often disclose that the patient is applying some substance which is acting as an external irritant. In this respect one should think of anusol or other hemorrhoidal suppositories, butesyn picrate and other ointments, particularly those containing resorcin. I am aware of at least one patient who is extremely sensitive to toilet paper, and, in general, I feel that the use of toilet paper should be prohibited temporarily, substituting damp cotton therefor. The seepage from mineral oil may produce anal irritation.

Intrarectal pathology may produce pruritus ani. Therefore, proctoscopic examinations and the help of a proctologist are advisable. Internal hemorrhoids, cryptitis, stricture, are representative of this group. Gastro-intestinal infections, such as amebiasis, colitis, and diarrheas, as well as infestation with the various intestinal worms, must be considered.

Noxious stimuli over afferent nerves from pelvic or abdominal pathology may be reflexly referred out over efferent fibers to the perineum, and be interpreted as a pruritus ani. Thus pregnancy, appendicitis, salpingitis and prostatitis may produce the pruritus. Illustrative of this point, but certainly a medical curiosity, is Maynard's case of pruritus ani, apparently caused by a huge umbilical calculus and cured by removal of it.

Certain dermatoses may localize around the anus and produce pruritus. This occurs fairly commonly in seborrheic dermatitis. Inspect the scalp, pubic area, and axillae. Eczema may localize around the anus as a part of eczema elsewhere on the body.

There are many systemic disorders which can produce itching of the anus. Possibly foremost among these stands diabetes. Other less common causes are icterus, leukemia, cardiovascular and renal breakdown. Allergy is responsible for some of these cases. I can recall one patient whose pruritus was cured by a milk-free diet. Or, as mentioned above, the pruritus ani may be due to a localized patch of a widespread allergic eczema.

Of the less tangible causes, one should mention the neuroses and psychic fixations. Stokes has emphasized this phase of the etiology. I have seen several such. One patient developed a pruritus vulvae et ani because of fear of intercourse with her husband, who had tuberculosis of the epididymus. A male patient of an age when his sexual powers normally were waning developed a pruritus ani as a defense reaction against his wife's Messalina-like demands. Such cases demand study by a neurologist.

* * *

DIAGNOSIS AND PROGNOSIS

H. P. Jacobson, M. D. (2007 Wilshire Boulevard, Los Angeles).—Diagnosis and prognosis of pruritus vulvae et ani depend upon discovery of the underlying causative mechanism, and upon the character of the etiologic agent in a given case. The sensation of pruritus, it will be recalled, may either be a local symptomatic expression of a disease process situated near to or distantly removed from the pruritic area, or the symptom-complex may constitute a disease entity *sui generis,* without any observable organic tissue changes *in situ* or in any other organ of the body to account for the trouble. For clinical diagnostic purposes, the disorder lends itself to study under the following classification:

1. Pruritus vulvae et ani due to local causes;

2. Pruritus vulvae et ani due to systemic or visceral diseases;

3. Essential pruritus vulvae et ani of unascertainable etiology.

1. *Pruritus Due to Local Causes.*—This form of the disorder may be encountered in both sexes at any age, though the anal form is observed most frequently in the adult male. Its inception may have its origin in irritating discharges from the bowel, rectum, or genito-urinary tract; in the local employment of antiseptic or contraceptive chemicals; in the mechanical or toxic action of protozoal organisms (Oxyuris vermicularis, pediculi, amebae, and trichomonas vaginalis); in bacterial infections (coli, streptococci, and gonococci); and

in fungal infections (yeast-like fungi, epidermophyta, and trichophyta).

The mechanism by which these different agents give rise to the annoying symptom of pruritus differs considerably. In cases of irritating discharges (regardless of whether these originate in cervical, vaginal, urinary, or anorectal-intestinal diseases, including hemorrhoids, anal fissures, etc.), the mechanism is probably that of a direct abrasive action upon the epidermal covering primarily, followed secondarily by an excitant effect upon the tactile sensory nerve organs of the involved parts, resulting in the sensation of pruritus.

In the parasitic form of the disorder, the mechanism concerned is largely determined by the character of the causative organisms. The oxyuria vermicularis, for instance, give rise to the sensation of itching or crawling by their very presence and locomotion across the mucocutaneous surface, thereby exciting (mechanically) the tactile sensory nerve organs of the parts. On the other hand, pruritus of bacterial or mycotic origin usually involves a mechanism more complicated, though benign, in character. The process here is essentially one of tissue defense, and consists, in addition to edema, of a mobilization of cellular elements in response to invading microörganisms, their toxins and metabolic products, and a direct excitant action of all these upon the sensory and tactile nerve organs of the parts, expressing themselves clinically in the sensation of pruritus.

2. *Pruritus Due to Systemic or Visceral Disease.*—Under this caption may be included those cases of pruritus vulvae et ani which may be traced to functional or organic tissue changes in some organ or viscus not directly connected with the pruritic area. Lack of space will not permit thorough consideration of this phase of the problem, but for purposes of illustration the following may be listed as frequent sources of origin:

(*a*) Foci of infection, no matter where located, but especially those situated in the urogenital organs, may reflexly or through direct toxic action excite the tactile sensory nerve organs of the anogenital tracts, and give rise to the sensation of itching.

(*b*) Portal congestion due to hepatic disease, or to local obstruction from tumors in the abdominal cavity, or from uterine pressure in the late stages of pregnancy, may reflexly, or through direct toxic action upon the tactile sensory nerve organs, give rise to pruritus.

(*c*) Intra-abdominal neoplasms, Hodgkin's disease, and the leukemias, possibly through a selective toxic action upon the tactile and sensory nerve organs, not infrequently give rise to anogenital pruritus.

(*d*) Intestinal stasis, nephritis, and especially diabetes, through toxic action of the respective metabolic products upon the tactile sensory nerve filaments of the anal and genital systems, not uncommonly express themselves clinically in the symptom of pruritus.

3. *Pruritus Ani et Vulvae Due to Undiscoverable Causes—Essential Pruritus.*—In this category belong the cases of so-called essential pruritus in which no causative mechanism is discoverable upon examination. It is probably a disease entity *sui generis,* and from the therapeutic and prognostic standpoints constitutes a most troublesome problem. The genital form is met with most frequently in the female sex during the climacterium, though it may be observed in both sexes at any period of adult life. The disorder is primarily a localized neurosis of the anal-genital tracts, usually without any observable organic mucocutaneous changes, except such as may be produced by the patient's scratching in an endeavor to obtain relief from itching.

Regardless of what group or category a given case of pruritus ani or vulvae may belong to, the essential and frequently only symptom for which medical relief is sought is pruritus. It is a most distressing sensation, and the victims will usually gladly submit to any form of painful therapy in order to be relieved of the agonizing itching, crawling, or pricking sensation. The itching may be persistent or paroxysmal in character, but is especially annoying after sunset, and particularly after retiring to a comfortable, warm bed. The desire to scratch constantly is so irresistibly agonizing that these patients not uncommonly are obliged to shun society and to become burdens to themselves and to their surrounding associates, friends, and families.

From what has been said, it is obvious that from the diagnostic standpoint the symptom of pruritus *per se* is of no more significance than is that of headache, backache, or any other similar complaint. Like headache or backache, it may be a clinical expression of any one of a number of disease entities, requiring diligent search and study for a correct diagnosis.

The examination of the patient should begin with the taking of a careful and pertinent history, in an endeavor to obtain a clue or clues which may enable the examiner to classify a particular case under the proper category. Such items as personal habits, diet, past illnesses, and the use of drugs (especially local antiseptics and contraceptives) should be gone into thoroughly, and the question of food sensitization should be accorded adequate consideration. This should be followed by a general inspection of the entire body, with a view of eliminating such humble offenders as Acarus scabiei and Pediculosis pubis as possible etiologic agents, and/or such other cutaneous conditions as may serve to throw light upon the existing pruritus.

The various systems and organs should receive such attention as the indications in a given case may require, and the laboratory procedures should be of such a character as to meet the indications in a given situation.

Dermatologic Earmarks. — From the dermatological standpoint, each type of pruritus vulvae et ani frequently presents some fairly characteristic objective features, susceptible, in a majority of instances, of correct interpretation by an experienced dermatological observer. Lack of space will only permit a general schematic outline of such suggestive features, and these may be submitted

(in accordance with classification previously outlined) as follows:

Group 1 (pruritus due to local causes). The common outstanding dermatological characteristics frequently separating this from the other two groups are : (*a*) sharp definition of the cutaneous eruption; (*b*) absence of infiltration; (*c*) mucocutaneous eruption preceding pruritus (excepting cases due to oxyuris vermicularis, and, occasionally, to contraceptive and antiseptic chemicals).

The cutaneous eruptions in pruritus cases due to bacterial infections (Streptococcus fecalis, Bacillus coli, or gonocci) are actually characterized by a good deal of inflammatory tissue reaction, frequently associated with vesiculation and oozing. Dermatitis produced by irritating discharges (from rectum or urogenital systems) is not uncommonly associated with a good deal of epidermal abrasion, and is subject to exacerbations and remissions, according to the amount and character of the discharge.

Pruritic dermatoses caused by members of the different genera of fungi (except in the presence of secondary bacterial infections) usually consist of sharply defined, noninfiltrated. only very slightly elevated, erythematous, scaly, dry patches, presenting little or no inflammatory reaction. Members of the monilia genus and some members of the trichophyton genus may, however, produce vesicular lesions, arranged discretely or coalescing to form sharply marginated patches. The vesicular lesions caused by these fungi are situated more deeply in the skin than are those produced by the bacteria and are, therefore, more tense and less subject to spontaneous rupture than are the vesicular elements caused by the latter organisms.

Group 2. In this, the so-called systemic type of pruritus vulvae et ani, the symptom of itching usually precedes the cutaneous eruption, though occasionally the reverse may be true. The eruption is commonly of the eczematous type, and consists of erythema, vesicles, and papules all combined in a given patch; or the latter may consist of any one or two of the three primary elements. Regardless, however, of the composition of a given patch, its outline is usually poorly defined, its surface may be moist and oozing or relatively dry, but infiltration sooner or later becomes a prominent feature.

Group 3. In this category belong the cases of so-called essential pruritus vulvae et ani. The disorder here is primarily and solely a pruritus without any observable organic mucocutaneous changes, and presenting no visible dermatological evidence of cutaneous disease. Such visible mucocutaneous pathology as may finally become manifest is usually secondary in character, a result of persistent mechanical insult inflicted by the patient (rubbing and scratching) in an endeavor to obtain relief from itching.

Prognosis.—Regarding the prognosis of pruritus vulvae et ani, little need be said in addition to what has been stated previously. The outcome of any case of pruritus depends upon the character of the etiological mechanism at work, and upon the ability of the attending physician to discover the cause and to employ proper therapeutic measures. Pruritus due to local causes lends itself to therapeutic management with a good deal of facility, and the prognosis is, accordingly, good in the majority of cases.

The prognosis of pruritus vulvae et ani secondary to systemic disease (second group) naturally depends upon the character of the underlying disorder responsible for the itching. In a general way it may be said that in the majority of cases (except those due to malignant neoplasms or organic spinal diseases) the prognosis is good, if the cause is discovered and removed or treated properly.

The prognosis of anal-genital pruritus of the third group—essential pruritus—is somewhat uncertain. By the older methods of treatment in vogue, the prognosis may be said to be essentially unfavorable in the majority of cases. The therapeutic results achieved are, at best, only temporary in character, and the pruritic parts, in a good many instances, following a series of relapses of itching in spite of treatment, sooner or later become infiltrated, leukoplakial, and, finally, epitheliomatous. With the presently available, newer methods of treatment by means of alcoholic and anesthetic injections, however, this aspect of the problem is assuming a different complexion, and a better prognosis is in the offing. Dr. Norman J. Kilbourne treated a good many cases of this form of pruritus vulvae et ani by means of injections, and is very enthusiastic over the therapeutic results he has been able to achieve. My own personal experience with this form of treatment is limited in character, but the results have been so favorable that I feel the method deserves wider clinical application with prospects of enhancing the prognosis in this form of the disorder immensely.

* * *

TREATMENT OF PRURITUS OF THE ANUS AND GENITALIA

Harry E. Alderson, M. D. (Stanford University Medical School, San Francisco).—An occasional annoying symptom to some, a persistent, very distressing one with agonizing periods of acute exacerbation to others, pruritus of the anus or genitalia is a subject of wide interest calling for discussion in these columns from time to time. In this Journal (January, 1927) was published an article by the author of this one, stressing the fact that this form of localized pruritus is largely a symptomatic condition due to causes acting "reflexly" and complicated by local conditions. My views regarding etiology have not changed, but I have some useful suggestions to present regarding treatment.

It goes without saying that one should not attempt to treat these cases without giving careful consideration to the patient's general condition. Failure to take into account the possibility of the existence of high-blood sugar, hypothyroidism, or hyperthyroidism, will explain some therapeutic disappointments. These conditions not only will produce increased vulnerability of the skin and

susceptibility to secondary infections, but such skins will lack the normal tendency to recover quickly from an injury. It is useful, too, to remember that occasionally pruritus ani will herald the onset of tabes dorsalis. In many cases indiscretions in diet, as well as food idiosyncrasies, will have to be attended to. Alcoholism, excessive use of tobacco, or drug addiction, when existent must be taken care of. Likewise when intestinal parasites are present they must be eliminated. I have known cases of anal pruritus where relief was not obtained until the patients stopped taking mineral oil. So a vitally important part of the treatment is found to be constitutional, and the gastro-intestinal tract should be the object of very careful consideration.

Pruritus of the anus and genitalia often exist together, and as the symptom frequently is produced "reflexly" by disturbances in some pelvic structure, the treatment is obvious. Local skin and mucous membrane changes, associated with the menopause or senility, produce some of our cases. Here endocrinotherapy may help, but one must rely mainly upon certain local measures, to be discussed presently. Quite often the removal of hemorrhoids, the eradication of rectal growths, fissures of ulcers, will relieve pruritus ani. The successful treatment of vaginal or uterine disease often will be followed by subsidence of pruritus vulvae.

If the patient has a seborrheal skin, the itching may be more severe, and eczema, and at times pyogenic infections, may result, greatly complicating the situation. Such cases may be much helped by cleansing drying lotions, roentgen therapy, and ultra-violet treatments, which will be discussed later.

One often hears of cases which are assumed to be due to the presence of a local mycotic infection. It is easy to demonstrate the presence of fungi and other organisms in scrapings from the anal and genital regions of most any individual. Even where there is obvious local inflammation from this cause, I believe that there usually are more important underlying etiologic factors, as already suggested. Naturally, one's treatment should include measures to combat local infections. I do not agree with those who claim that most cases are due entirely to local mycotic infections.

Many cases are complicated by overtreatment. Often the skin and mucosa are so damaged, and all one can do for a few days is to apply most soothing preparations until healing takes place. A weak cocain ointment or liquor alumini subacetatis compresses (containing Burrow's solution, diluted sixteen times) will be very useful here. This preliminary treatment is also very beneficial when there is edema and inflammation due to scratching. Tiny abrasions are very apt to be the starting points of widely spread itching. Applications to these abrasions of a five or ten per cent silver nitrate solution are indicated. When the results of excessive local stimulation are thus palliated, systematic curative therapy can be instituted.

If patients have to scratch (and they often do), they can be taught to press hard on the itching spot with the fingers covered with thick cotton cloth. Of course, it is better when this occurs to apply some of the salves or lotions to be discussed later; but it is not always convenient to do so. As the surface is usually moist the drying of the same by a clean cotton cloth, absorbent toilet paper, or the use of a carbon tetrachlorid lotion, usually gives relief which may last through the night.

Paroxysms of perianal itching often are started by the appearance of a very small amount of rectal secretion finding its way along the radiating lines and creases or tiny fissures that are present. This occurrence sometimes may be made less likely by the administration of a small cleansing rectal enema at bedtime. Locally, a "dry cleaner," like carbon tetrachlorid c. p. diluted one-tenth with albolene or lanolin and two-thirds with dilute alcohol, is very helpful. The preliminary smarting which results also has a good antipruritic effect. This lotion also may be applied on soft absorbent toilet paper after bowel movements.

The carbon tetrachlorid lotion (which I originated in 1923, *Archives of Dermatology and Syphilology,* 8:411-415, September, 1923) should be diluted, for some individuals become dizzy if they inhale much of it. This preparation, being a good solvent, removes secretions and excretions from the follicles, ducts and creases in the skin, and acts as a bactericidal and fungicidal agent. The addition of two per cent camphor will increase its antipruritic and drying effects. It will be helpful to cleanse the regions morning and night with this lotion. Should the skin become too dry, more oil may be added to the solution or one-half per cent phenol in vaselin may be applied.

I have practically abandoned the local use of powders in this condition, as they are difficult to apply. The hair and other factors make it impossible to properly powder the skin. Occasionally, however, the following may be useful:

℞ phenol 0.6
acid salicylic 2.0
zinc oxid 25.0
amyli q. s. ad. 60.0
M. in fine powder
Sig: Apply freely

A simple ointment, containing ten per cent of calomel, often is helpful. Also one or two per cent of phenol, with one per cent menthol in olive oil or simple ointment, will give relief. It must be remembered that phenol preparations may in time cause local necrosis.

Tars are often recommended. They will dry the area; they will also relieve itching. The fact that they have carcinogenic properties is, in my opinion, a very serious objection to their use here. This is particularly true of crude coal tar. I rarely use them around the anus, but at times have prescribed a weak liquor carbonis detergens ointment with satisfactory results. Even in these cases, however, I have felt that possibly a two per cent preparation of camphor in simple ointment, or a plain grease alone, would have done as much.

The application of adrenalin solution, several times daily on pads of gauze, by contracting the capillaries, may be very helpful. This is particularly true if there is eczema.

Roentgen therapy has a local sedative and a drying effect. It should be used most cautiously, bearing in mind the danger of producing radiodermatitis and also possible untoward effects on the testicles. We usually administer one-quarter of a skin unit filtered with one millimeter of aluminum weekly, and are careful not to exceed one full skin unit within a month. We have seen some advanced cases of radiodermatitis (and in one instance a superimposed carcinoma) resulting from overtreatment at the hands of others. One patient had gone the rounds of several radiologists, who had given him many treatments without knowing that the individual had had the same given by others. His intergluteal region was covered with a network of telangiectases, and keratoses were beginning to appear. Of course, the average radiologist would never give this treatment without being sure of the past history. Roentgen treatment will relieve for weeks at a time, but the condition will flare up again if the causes are not removed.

Ultra-violet exposures may be helpful by toughening and drying the skin. Its superficial bactericidal and fungicidal action also is beneficial.

Surgical removal of the skin involved, nerve resection, nerve injection, and other measures to produce complete local anesthesia will give relief. However, the results are apt to be only temporary, as nerve regeneration occurs.

To do full justice to our patients we should exert every effort to discover and eradicate the underlying causes, and not be satisfied with local therapy alone. The foregoing suggestions apply to the treatment of pruritus of the anus, as well as that of the genitalia.

A Medical Trade Union.—The Medical Practitioners' Union is a trade union, which was formed in 1915 by physicians who thought that an organization on these lines, which have never been adopted by the British Medical Association, was desirable. It is a smaller body and has nearly 6,000 members. It has joined forces with the other labor unions. The General Council of the Trades Union Congress has accepted the proposal of the Medical Practitioners' Union for affiliation. This is the first time that a medical society has been linked up with the Trades Union Congress. In a press interview the secretary of the union stated that the object of this move is mainly to protect members who are engaged by county and municipal authorities. "Where negotiations are needed," he said, "it will give added strength, but it must not be taken that this affiliation means the possibility of a strike against the sick. Every union affiliated with the Trades Union Congress is governed by its own rules and that, of course, applies to us. It is unthinkable that there should be a strike against people who are ill, nor would anybody expect doctors to take such a step. We are endeavoring to help many members of our union, and to do that we have had to apply wholly as a union." It is one of the objects of the trade unions to be able to declare a general strike, and one actually took place a few years ago but was unsuccessful. The government was equal to the emergency and essential services were maintained by volunteers. It is understood that the application from the Medical Practitioners' Union was accepted without qualification, no specific point being raised on the question of a general strike. The calling out of the physicians in the case of another general strike would be the reductio ad absurdum of trade unionism. The majority of the physicians in this country abhor this movement by a section of the profession. It is certainly due to the great increase of state interference in medical practice in recent years, of which the most important manifestation is health insurance of the wage earners. The idea is, as indicated, to confront the state or the local authorities who employ physicians by a powerful organization.

THE POSITION OF THE BRITISH MEDICAL ASSOCIATION

The question has arisen: Can these medical trade unionists retain membership in the British Medical Association, which is opposed to anything that savors of the political? In a press interview the secretary of the Medical Practitioners Union said that they were not concerned with politics but only with medical politics—a vastly different thing. Both organizations were voluntary bodies, and physicians could be members of both, just as they could be members of two golf clubs. He saw no reason why the two bodies should clash. However, Doctor Anderson, medical secretary of the British Medical Association, has expressed a different view in another press interview. He agreed that physicians may still subscribe to membership in both organizations but said: "They must be men of elastic conscience. Personally I could not do it, because I do not believe in the union's methods. In affiliating with the trade unions they are trying to anticipate the political movement in this country. [He evidently refers to a possible victory of the labor party.] The union will alienate the sympathies of a good many of its members by this move. The British Medical Association does not need to be a trade union to fulfill its objects. Nearly 60 per cent of the profession are members of the association and the turn of events does not perturb us in the least."—London News Letter, *Journal of the American Medical Association.*

Advances in Ovarian Therapy.—A gynecologist, whose name is known from coast to coast, recently commented in the *Journal of the American Medical Association* (February 23) about the cost of ovarian therapy. "It is greatly regretted," he wrote, "that the American products have not been available at prices that justify their preference or at least their being on a parity with the imported material."

Physicians who have read this statement will be interested in the announcement from the Squibb Laboratories that the potency of Amniotin, a physiologically tested preparation of the ovarian follicular hormone, has been increased three-fold and the cost per unit has been reduced to about one-tenth of its former price. For hypodermic administration, Amniotin in Oil is now distributed in one cubic centimeter size ampuls, containing 8,000 and 2,000 International Units per cubic centimeter.

Amniotin Capsules and Pessaries (vaginal suppositories) now contain 1,000 and 2,000 International Units, respectively. The price of these packages is now so low as to compare favorably with the cost of insulin.

The kernel of the scientific outlook is a thing so simple, so obvious, so seemingly trivial, that the mention of it may almost excite derision.

The kernel of the scientific outlook is the refusal to regard our own desires, tastes and interests as affording a key to the understanding of the world.

Stated thus baldly, this may seem no more than a trite truism. But to remember it consistently in matters arousing our passionate partisanship is by no means easy, especially where the available evidence is uncertain and inconclusive.—Bertrand Russell.

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Leaflet Regarding Rules of Publication.— California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this journal write to its office requesting a copy of this leaflet.

EDITORIALS*

YOSEMITE ANNUAL SESSION

This Year's Annual Session Voted a Success.—The sixty-fourth annual session of the California Medical Association, the third to be held in Yosemite since the founding of the Association in the year 1856, has now taken its place in the long annals of the society. It will be remembered as a session with a registration unusually large, in an environment nowhere to be excelled for its natural beauty, and for meetings at which the scientific papers were of excellent standard, with large and appreciative audiences; and for section conferences where business of exceptional importance was transacted by the delegates in an expeditious, but fraternal manner.

The Hotel Ahwahnee, Camp Curry and Yosemite Lodge, and their cabins and tent-houses, were all taxed to capacity; but everywhere was the spirit of good fellowship in evidence, going far in overcoming some of the occasional inconveniences. The total registration was 951, while at the dinner in the Camp Curry pavilion, given in honor of President Clarence G. Toland, almost twelve hundred guests were seated, with an overflow group of about three hundred at the Hotel Ahwahnee.

The scientific program, as printed in the April issue, was carried through splendidly. The Association is not only much indebted to the guest speakers, but also to the many members who, in the section programs, presented papers of worth on work done in the last and preceding years.

The full report of the transactions of the House of Delegates, now being transcribed by the official stenographer, will be printed in the July number. A perusal of the various items submitted to the House, and the decisions reached on many matters vital to the progress of organized and scientific medicine, should make every member of the California Medical Association realize the important functions of the House of Delegates, when it exercises its responsibilities in the election of officers and the determination of Association policies. To be a member of the House of Delegates is both an honor and an obligation, and should so be regarded by all.

* * *

The Retiring President, Dr. Clarence G. Toland.—The address of the retiring president, Dr. Clarence G. Toland, is printed in this issue as first of the original articles, and its perusal is commended to every member of the Association. The generous reception given to President Toland's remarks show that his personal points of view were in harmony with those of a very large number of California Medical Association members. The Association is deeply indebted to Doctor Toland for many efficient services, which he so unselfishly rendered during his term of office. His visits to numerous component county societies aided greatly in bringing into being a kindlier approach in the discussions of some of the important economic and welfare problems facing the profession in these troublous times. The outpouring of members at the dinner in his honor was a tribute in part to both his work and his genial personality. As he laid aside the cares of his office, he took with him the hearty good wishes of all his colleagues.

* * *

President Robert A. Peers of Colfax.—With the close of the session on Thursday, May 16, Dr. Robert A. Peers of Colfax assumed the office of president. Doctor Peers needs no introduction to members of the California Medical Association who have kept in touch with scientific and organized medicine. His work in his own specialty, and his labors for the Placer County Medical Society and lay fellow citizens, are known to scores of physicians. Up in the Mother Lode country of California, his is a name to conjure with; and for no other reason than that of ever willing, generous and able service for all to whom he could be of aid. He is a representative of the splendid type of the all-around physician more frequently met with, perhaps, in the western than in the eastern states. Doctor Peers has had a

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

long career in organization work, and the example he sets in still modestly acting as secretary of one of the component county societies of rather limited membership may be pointed to as worthy of emulation. All who personally know Doctor Peers are confident that the welfare of the Association, while in his keeping, is in safe hands.

* * *

President-Elect Edward M. Pallette of Los Angeles.—When the new constitution and by-laws of the California Medical Association were adopted at San Diego in the year 1929, the honor of becoming the first speaker of the House of Delegates was placed on the shoulders of Dr. Edward M. Pallette of Los Angeles. At each succeeding annual session, Speaker Pallette was reëlected without opposition. This year, however, the House of Delegates chose not to return him to that office, but to bestow upon him another honor —that of president-elect.

For several years, Doctor Pallette has been vice-president of the California State Board of Health, and in Los Angeles, where he has played an important part in the advancement of scientific and organized medicine, his election to the high office of president-elect meets with universal approval. During his years of service as speaker, he has been a member of the Board of Councilors and Executive Committee; and in these positions his wise counsel will continue to be felt.

* * *

Speaker W. W. Roblee of Riverside.—The new speaker of the House of Delegates is Dr. W. W. Roblee of Riverside, who has heretofore served as member of the Council from the first district. Doctor Roblee, when in the chair, will be found to be an able successor to Speaker Pallette. His decisions may be counted upon to be marked by both clearness and fairness.

* * *

Other Newly-elected Officers.—In the fourth councilor district, the vacancy created by the resignation of Dr. Fred R. DeLappe was filled by the election of Dr. Axcel E. Anderson of Fresno. Other members of the Council and delegates to the American Medical Association were reëlected by acclamation, a tribute to their past services and their personal popularity. These included the following:

First district councilor, Dr. C. L. Emmons of Ontario; seventh district councilor, Dr. Oliver D. Hamlin of Oakland; councilor-at-large, Dr. Harry W. Wilson of Los Angeles; councilor-at-large, Dr. Morton R. Gibbons of San Francisco.

Delegates to the American Medical Association, Dr. Elbridge Best of San Francisco, Dr. Lyell C. Kinney of San Diego and Dr. Fred B. Clarke of Long Beach.

Alternates to the American Medical Association, Dr. Robert S. Stone of San Francisco, Dr. Harry H. Wilson of Los Angeles and Dr. A. J. Scott of Los Angeles.

STATUS OF HEALTH INSURANCE LEGISLATION IN CALIFORNIA

California Newspapers Announce that No Health Insurance Legislation Will Be Enacted This Year.—At the time these comments are being written, the California newspapers are printing Sacramento dispatches concerning the fate of the two major health insurance bills, namely, Senate Bill 454, and what might be called a companion bill in the Assembly, Assembly Bill 1097. Senate Bill 454 in its original form was drafted by the California Medical Association Committee of Six, after authorization by the House of Delegates at the special Los Angeles session, the bill having been submitted to the upper house on April 12 by the Senate Interim Committee (Senators Dan E. Williams of Tuolumne County, Edward Tickle of Monterey County and Leonard J. Difani of Riverside County); while Assembly Bill 1097 was introduced on May 10 as an amendment to a skeleton bill having that number, by Assemblyman H. Dewey Anderson of Santa Clara County, with other sponsors not announced.

At Yosemite the adjournment of the House of Delegates of the California Medical Association took place on Wednesday evening, May 15. Two days later, the newspapers announced that neither of these health insurance bills had much chance of passage at this fifty-first session of the California Legislature. This similar action by the Senate and Assembly was not taken because of advices from, or with the sanction of the California Medical Association Committee of Six that these bills should be withdrawn at this time, but because the legislative reference committees and individual legislators, presumably feeling that the bills could not go on to passage in the turmoil of the last days of the session, in the press of other business, deemed it wise that the measures be not pressed for passage at this session. With the per diem pay to legislators legally coming to a close on May 22, it is stated that the legislature will probably adjourn some day between May 25 and June 1. It is almost safe to assume that neither of these bills will become a law during this fifty-first legislative session. They remain on the calendars, to die there.

* * *

California Senate Appoints a New Interim Committee.—The Senate, two days after the close of the Yosemite session of the California Medical Association, was the first to take up the ultimate disposition of Senate Bill 454, that body having voted that a new interim committee should be appointed, this committee to consist of Senators Dan E. Williams of Tuolumne County, Edward H. Tickle of Monterey County, Leonard J. Difani of Riverside County, William F. Knowland of Kings County, and A. L. Peirovich of El Dorado County, the committee to elect its own chairman. In the above committee, Senators Williams and Knowland will continue as members of the fifty-

second legislature two years hence; but Senators Tickle, Difani and Peirovich must go before their respective districts for reëlection.

* * *

*California Assembly Likewise Appoints an Interim Committee.**—Not to be outdone by their Senate confrères, the Assembly voted, a day later, to bring into existence an Assembly Interim Committee of five members.†

* * *

The Question of Separate and Conjoint Reports, and of Supporting Finances.—Whether these two committees, one from the Senate and one from the Assembly, will join forces and make one study on the needs of a state health insurance system for California, or whether they will act independently, has not been announced. In the present depleted condition of the State treasury, whatever public funds may be allocated for such investigations, will necessarily be of somewhat minor amounts.

The California Medical Association will have spent some $35,000 of its own reserve funds as an expression of its interest in the solution of these problems; but like the State treasury, it is now where it must stop, look and listen before making additional appropriations. Whether federal aid will be forthcoming is also not known, the SERA having already expended more than $60,000 in these California investigations carried on during the years 1934 and 1935. Two years ago, it was stated that several of the large eastern foundations, such as the Milbank, were anxious to take a part in the California surveys; but whether such endowing institutions will now come into the California picture, to aid the two new interim committees, is not known at this time.

* * *

Action of the House of Delegates on the March 2 Special Session Resolutions. — The minutes of the House of Delegates, which will be printed in the July issue, presents the official actions taken at Yosemite. In the meantime it may suffice to state that the stipulations in the special session Resolution No. 2—printed on page 187 of the March,

* Editor's Note.—The California *Assembly Daily Journal* of May 18, 1935, printed Assemblyman Anderson's resolution creating an Assembly Interim Committee to study and bring in a report on the need of a health insurance law in California. It has a double interest in that it incorporates in its first "Whereas" the resolution passed by the Senate, in which that House also created a Senate Interim Committee to take up the work of the Interim Committee of the present or fifty-first legislative session. From the *Assembly Daily Journal* we quote:

RESOLUTION

"The following resolution was offered:

"By Mr. Anderson:

RESOLUTION

"WHEREAS, The Senate of the fifty-first session of the California Legislature adopted a resolution May 17, 1935, in terms and figures as follows:

"WHEREAS, The development of more adequate health services at rates within reasonable reach of self-supporting individuals and families of small and moderate incomes is essential to promote the comfort, health, safety, economic security and general welfare of the people of the State of California; and

"WHEREAS, The committee appointed by the Senate April 19, 1933, composed of Senators Williams, Tickle, Difani and its coördinator secretary, Dr. Celestine J. Sullivan, have performed a distinguished public service by devoting two years of disinterested and arduous work at their own expense to the study of health insurance and the investigation of the high cost of sickness and the preparation of a very valuable report published in the *Senate Daily Journal,* April 12, 1935; and

"WHEREAS, The useful data assembled by the committee show the complexity and magnitude of the questions involved and the fundamental importance of vital underlying problems which affect the life of the commonwealth to such an extent that further study is deemed desirable in order that laws passed by this session or previous sessions of the California Legislature, relating to medical care, may be revised to suit changed conditions and made to conform to reasonable amounts which the tax-paying public can afford; now, therefore, be it

"Resolved, That a Committee of Five members of the Senate be appointed by the President of the Senate to continue the study of present methods of medical and hospital care and the economic order under which they operate and the practical application of such laws as now exist or be adopted at the fifty-first session of the California Legislature so that accurate and up-to-date information may be available for the 1937 session of the Legislature; and be it further

"Resolved, That said committee shall proceed to organize by the election of one of its members as chairman and by the selection of a coördinator secretary and the adoption of such rules as it shall deem necessary or advisable to enable it to carry into full force and effect the duties herein imposed; and be it further

"Resolved, That said committee is authorized to hold public hearings at any place in the State of California at which hearings the people shall have opportunity to present their views to the committee; and be it further

"Resolved, That said committee is hereby authorized and empowered to do all things necessary to make a full and complete investigation of the matters herein referred to and to require the production of records, books, agreements, contracts, fee schedules, documents, and papers of every kind; to issue subpenas and to compel attendance of witnesses and to procure testimony. Each of the members of said committee and the coördinator secretary chosen by the committee is hereby authorized to administer oaths and all the provisions of Article VIII of Chapter II, Title I, Part III of the Political Code of the State, relative to the attendance and assemblage of witnesses before the Legislature and committees thereof and during the interval between sessions; and be it further

"Resolved, That the committee in order to make a comprehensive investigation of the problem, may accept donations from philanthropic persons, foundations and others interested in the study and investigation and shall expend such donations in carrying out the purposes hereof; and be it further

"Resolved, That said committee shall report and make recommendations to the fifty-second session of the Legislature during the session commencing in January, 1937, before the constitutional recess thereof; and

"WHEREAS, The Assembly of the California Legislature has equal interest with the Senate in the health of the people which is the most valuable resource of the State and the most priceless possession of its citizens; and

"WHEREAS, The Senate has appointed a Committee of Five of its members to make a comprehensive investigation in accordance with the terms of its resolution of May 17, 1935; now, therefore, be it

"Resolved, That a Committee of Five members of the Assembly be appointed by the Speaker, having the full powers provided in the Senate resolution of May 17, 1935, as embodied herein, to confer and coöperate with the Senate committee in fact-finding studies and the formation of a plan to promote the health and general welfare of the people of California.

"Resolved, That the sum of $2,500, or so much thereof as may be necessary for the purpose of defraying the expenses of the committee and the cost of its investigation, is hereby made available and appropriated for the use of the committee out of the contingent fund of the Assembly, and the State Controller is authorized and directed to draw his warrants in favor of the person or persons entitled thereto for such expenditures as may be certified to him from time to time by the chairman of the committee and the State Treasurer is hereby authorized and directed to pay the same.

CONSIDERATION OF RESOLUTION BY MR. ANDERSON

"Resolution by Mr. Anderson read.

"Mr. Anderson moved the adoption of the resolution.

"The question being on the adoption of the resolution.

"The roll was called, and the resolution adopted by the following vote:

"Ayes, 58; noes, 1."

† Editor's Note.—The Assembly Interim Committee, as announced by Speaker Edward Craig of Orange County, consists of Assemblymen H. Dewey Anderson (sociologist and educator) of Santa Clara County, Gordon W. Corwin (orange grower) of San Bernardino County, Thomas J. Cunningham (lawyer and educator) of Los Angeles County, James J. McBride (insurance) of Ventura County, and Ralph W. Wallace (attorney) of San Diego County. This committee will elect its chairman. The occupations listed above in parenthesis are taken from the "Assembly Weekly History."

and page 272 of the May issues—were in no manner modified at Yosemite. At the Yosemite meeting, members of the Committee of Six, who sat in the House of Delegates, stated on the floor that if Senate Bill 454 or Assembly Bill 1097 failed in their final form to measure up to the stipulations outlined in Resolution No. 2, the bills would be promptly withdrawn.

However, the actions taken independently by the California Senate and Assembly, prevent that dilemma from arising.

* * *

The Present Status of the Health Insurance Bill.—For the present, the record of the California Medical Association is that its members have given active coöperation in promoting a cross-section survey of sickness incidence and costs in California, and of having aided in the draft of a bill (S. B. 454) submitted on April 12, which received, however, many amendments, and which in its amended form on May 17, was withdrawn from the Senate calendar. It has been stated that before the legislature adjourns, Assemblyman Dewey Anderson would submit amendments to Assembly Bill 1097, to permit its final printed form to conform in the main with Senate Bill 454, as that measure was originally introduced by the Committee of Six.

* * *

Course of Future Action by the Association.—It now devolves upon the Council to consider the future course of action. The annual meeting of the trustees of the Association has been called for Saturday, May 25, and on that day the Council of the California Medical Association will also convene. At that meeting the future course of procedure will probably be outlined. The decisions reached, in conjunction with the minutes of the House of Delegates, will probably be announced in the July issue.

* * *

Thanks Due to the Committee of Six.—In bringing these comments to a close, it is only proper that attention should again be called to the efficient work performed by the Committee of Six (Doctors Junius B. Harris of Sacramento, Walter B. Coffey of San Francisco, Fred R. DeLappe of Modesto, T. Henshaw Kelly of San Francisco, E. T. Remmen of Glendale and Joseph Catton of San Francisco). Theirs was no easy task, and their faithful services, as well as those of the members of the Advisory Committee, deserve and will elicit the thanks of the members of the California Medical Association.

* * *

Every Component County Society Should Continue Its Study of Health Insurance Problems and Plans.—In conclusion, may not the importance of continued study of sickness insurance be here emphasized? The action of the present legislature has not solved these problems. They will be found facing us two years hence, perhaps in more militant manner than in that of yesterday and today. It is most important, therefore, that every member should acquaint himself with all phases of the subject.

In the larger component societies, medical economic sections, to meet quarterly, bimonthly or monthly, could well be brought into being. In the smaller societies, two evenings each year—one in the spring and the other in the fall—might well be devoted to a discussion of these topics, with presentations by both local and guest speakers. In the larger societies, if economic sections are formed, at least two general meetings of the entire membership should be given over to suitable programs.

A perusal of the speeches made at the Los Angeles special session and printed in this issue,* will at once indicate to the readers what radically different opinions are held by some of our members. It should, nevertheless, be possible, through friendly discussion of insurance system facts in relation to sickness incidence and costs, for members of the profession to meet on a common ground, so that the interests of the lay public and of the medical profession will be both adequately and properly protected. If we are not educated in these matters, we shall find ourselves in the future in unfortunate situations.

OTHER LEGISLATION

The fate of the bills in which members of the medical profession have special interest is still in doubt. Brief mention may be made of several:

Qualifying Certificate Act (A. B. 1552).—This bill will die in committee. Many amendments thereto were submitted, and others suggested and sent to the special committee, whose report appeared on page 317 of the April issue. The House of Delegates at Yosemite voted to instruct the Council to continue its studies for such a law, and to submit the same as an initiative act at a future State election. This recommendation is in line with the advice of the Special Committee when it secured the Council's permission to introduce Assembly Bill 1552, as a means of better provoking suggestions for possible amendments.

* * *

Senate Bill 471: "Relating to Medical and Hospital Insurance Service."—It is stated, when Assembly Bill 1097 (the number of the health insurance companion bill to Senate Bill 454) was being discussed in the Assembly chamber before the Committee on Social Welfare, that Senate Bill 471, introduced by Senator L. J. Difani of Riverside, was plucked from the bottom or near-bottom of the committee file, to pass out to the Senate floor and go on to passage in the upper House. At this writing, Assembly Bill 471 has had its third reading in the Assembly, but is being bitterly contested. Many members of the Association have been consulted in regard to this proposed law. What the end-result will be cannot be foretold at the time these comments are written.

* The speeches made at the special sessions of March 2-3 are printed in this issue, on pages 445-460 inclusive.

A general outline of Senate Bill 471 was given in the following article, taken from the San Francisco *Examiner:*

The California Medical Association has raised objections to Senate Bill 471, which provides for medical and hospital service insurance. The bill has passed the Senate and is on the third reading file of the Assembly.

Chief objection made to the bill, as stated by the Association's representative, is that "it converts the practice of medicine to the business of insurance and profit from the sick."

Protection Not Given

It is also asserted that the bill provides no minimum standards of care for the protection of the patient and gives no authority for fixing such minimum standard and also by implication does not prohibit solicitation, but authorizes it.

The bill, according to the Association, would by implication allow a physician to use a name other than his own if he were an insurer under the act while, it is claimed, such practice is prohibited by the Medical Practice Act.

Held Unnecessary

It is averred by the Association that the bill is unnecessary to control and regulate certain persons and associations in that "the existing laws and court decisions now take care of that."

It is stated by the Association that the bill fails to furnish the insurance department with necessary expert assistants to enforce its provisions. Objection is further stated by the Association in that it is claimed the bill would result in "commercialism of medicine and will not even tend to solve the problems connected with the cost of sickness." The statement is made for the Association:

"If it is deemed necessary by the insurance department that hospital service insurance be regulated, this can be done by amending the bill to delete all professional medical service."

* * *

Physicians' and Hospital Records (A. B. 2158).—This bill would have given attorneys the right, without let or hindrance, to inspect and copy physicians' and hospital records when "there shall be either pending or contemplated litigation, in which said records will, in the opinion of said attorney, be helpful to the cause of his client." This bill deservedly died in committee.

* * *

So-called Antivivisection Bill (A. B. 2401).—In popular parlance this measure, proposed by the business manager of the Butchers' Union of Alameda, was known as the "dog bill," and in the "committee pound" it went into a quiet death. Some of its proponents now talk confidently of resorting to an initiative to bring about the enactment of such a law. If that happens, the dogs of war will surely be unleashed.

* * *

Assembly Bill 1037: "An Act to Safeguard the Public Health by Regulating the Use of X-Rays on Living Persons in California."—The object of this bill, introduced by Assemblyman J. E. Peyser of San Francisco, is to confine the use of x-rays to reasonably qualified persons. It would do away with the use of such a potent agent as x-rays by beauty-parlor operators or shoe-fitting establishments. While recognizing the rights of physicians and others, its provisions would prevent persons, not qualified, from receiving licenses to use this modality. The licensing power was placed under the California State Board of Health instead of under the State Board of Medical Examiners, in deference to osteopathic and other groups who might object to the State Medical Board.

* * *

County Health Insurance Systems (A. B. 2397).—This is the Heisinger bill. Its provisions for medical service have been amended out of the bill, but it still contains provisos that could be a real menace to medical standards.

* * *

Restrictions on Granting Doctor and Other Degrees (A. B. 1765).—The racket that has arisen through lax laws governing the incorporation of educational institutions having the right to grant doctorate and other degrees was briefly commented upon, on page 273 of the April issue. Assembly Bill 1765 places additional safeguards on the granting of degrees, diplomas and certificates. The measure has passed out to the Assembly floor and may go on to passage. The amendments to existing statutes proposed in Assembly Bill 1765 would inflict no hardships on legitimate institutions, but would go far in doing away with fly-by-night rackets.

* * *

Much might be written of a dozen or more measures of special interest to groups of members, but it is not possible, in this short time before going to press, to prognosticate the outcome. Comment on the results, therefore, will be held over for the July issue.

SPECIAL SESSION SPEECHES ON HEALTH INSURANCE

Speeches and Remarks Made at the Special Session of the California Medical Association House of Delegates Printed in This Issue.—The official minutes of the special session of the House of Delegates of the California Medical Association, held in Los Angeles on March 2 and 3, 1935, were printed on pages 194 to 207 of the March issue. At that time the speeches by delegates had not been transcribed, and since then special annual session program and other features have delayed their publication.

In this issue will be found most of the speeches made at the special session, on both sides of the health insurance question.* The attention of readers is called to these discussions because the action taken by the House of Delegates at that time, before its members voted favorably upon the outstanding resolution (Ingber Resolution No. 2) of that special session, was more or less swayed by the arguments put forth. The remarks made by delegate speakers are as pertinent today as then, and to members of the California Medical

* The special session speeches are printed in this issue, on pages 445-460.

Association they should still have special interest and value because the opinions then presented reflect the points of view not only of the individual speakers, but of considerable groups of members throughout the State, holding to somewhat similar outlooks. Health insurance problems will continue to have a prominent place in medical and lay thought for years to come. A perusal of the speeches printed in this issue can be thought-stimulating, if readers will but ask how they themselves would answer the various statements put forth by the delegates who spoke on the several phases of the topic, and for the consideration of which the special session was convened at Los Angeles on March 2 and 3. For two days the members of the House listened with marked attention to the debates. Now, members-at-large, in leisure moments, may well review the proceedings in retrospect. Take the time, therefore, to read these speeches. If you do not approve of what is there said ask how you yourself would answer, or what kind of a presentation you yourself would have made, to express your own understanding of the various problems.

EDITORIAL COMMENT*

HYPOGLYCEMIA IN DIABETES

It is well known that depancreatized animals develop hyperglycemia, and that this hyperglycemia may be controlled or dropped to normal or subnormal levels by the artificial injection of insulin. It is not so well known that a certain number of these depancreatized animals die in a state of hypoglycemia without having had any artificial injection of insulin. Autopsy on these animals reveals a marked fatty degeneration of the liver.[1]

The existence of a sufficient amount of functioning liver tissue is necessary to maintain sugar up to normal or hyperglycemic levels. There is abundant evidence to support the idea that hepatic damage causes hypoglycemia in non-diabetic animals.[2] Furthermore, we conclude from the work of F. C. Mann and T. B. Magath that when a dog is depancreatized and hyperglycemia results, and then the liver is removed, the blood sugar falls and the dog dies in a state of hypoglycemia. These investigators say: "The experiments prove conclusively that the liver is absolutely necessary for the maintenance of the blood-sugar level in the hyperglycemic animal in the same manner as in the normal animal. The increase in blood sugar following pancreatectomy is dependent on the presence of the liver. Without an adequate amount of functioning liver tissues, the increase in blood sugar, following pancreatectomy, could not occur."

It is the general opinion that the typical hyperglycemic response of the depancreatized animal is much better when the animal is fed pancreas by mouth. That this is not due to any absorption of insulin from the intestine is also well known. It is suggested that the external enzymes of the pancreas have some beneficial effect on these animals, and that a possible cause of the fatty degeneration of the liver in depancreatized animals is the absence of the pancreatic enzymes.[3] In support of this idea, non-diabetic animals with permanent pancreatic fistulae show this fatty degeneration of the liver with the resultant hypoglycemia. Such animals are greatly hypersensitive to insulin.[4]

Paralleling this experimental work, I. T. Zeckwer [5] reports the case of a man who was diabetic. He had been taking insulin for some time, but gradually developed an increased sensitivity to the insulin, so that it was withdrawn. A condition of hypoglycemia persisted, which was relieved only by the intravenous injections of glucose. He finally died in a state of hypoglycemic shock. Autopsy revealed a marked fatty degeneration of the liver, a complete obstruction of the pancreatic duct with stones and a marked atrophy, not only of the isles of Langerhans, which accounted for his diabetes, but also of the structures which normally secrete pancreatic juice. The hypoglycemia was apparently due to the degeneration of the liver, and the degeneration of the liver was due to the absence of pancreatic enzymes.

It is suggested that when the liver is damaged through the loss of the external secretions of the pancreas, hypoglycemia may result in a patient with diabetes, even in the absence of treatment with insulin.

College of Medical Evangelists.

W. E. Macpherson,
Loma Linda.

* This department of California and Western Medicine presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Fisher, N. F.: Am. J. Physiol., 67:634, 1923.

2 Mann, F. C., and Magath, T. B.: Arch. Int. Med., 37:797, 1923.

3 Hershey, J. M., and Soskin, S.: Am. J. Physiol., 98:74, 1931.

4 Berg, B. N., and Zucker, T. F.: Proc. Soc. Exper. Biol. and Med., 29:68, 1931.

5 Zeckwer, I. T.: Arch. Int. Med., 54:330.

The First "Skyscraper" Hospital in Europe.—The new Beaujon Hospital has just opened its doors in Paris. An event that would attract little attention in the United States is hailed here as the beginning of a new era in hospital construction. The majority of continental hospitals are composed of a group of one to, at the most, three-story buildings, scattered over a relatively large area. The new Beaujon Hospital is eleven stories in height and has a capacity of 1,100 beds, with a large out-patient department. There are only fourteen beds in each ward, and four of such wards form a service under the charge of a single attending physician. The laboratories and rooms for research work are in immediate proximity to each service. The cost of construction has been $4,500 per bed and it is hoped that the cost of maintenance may be materially decreased through centralization in one building.

We spend six times as much for funerals and tombstones each year as we appropriate for public health service.—James M. Parrott, M.D., State Health Officer, North Carolina.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

A MESSAGE FROM PRESIDENT PEERS

To the Members of the House of Delegates—Greeting:

Your President wishes to express to the House of Delegates collectively, and to the members of the House individually, his extreme pleasure because of the manner in which the Delegates at the Yosemite meeting showed, by their actions, that they place the interests of organized medicine, and the interests of the public, whom they serve far in advance of private desires, personal gain, or of personal ambition.

During the past years it has seemed, at times, to your President that, in the heat of argument, in the great differences of opinions held by members of the Association and by its duly-elected representatives, the interests of the profession might be momentarily forgotten. The word "momentarily" is used advisedly because, in his thirty years' experience in medical society work, he has learned that only an infinitesimal proportion of the Association members is actuated by other than the highest motives when engaged in its activities. But, in the heat of battle, in the clashing of different opinions and philosophies, actions may be taken which would work immeasurable harm to the profession and which, on cooler thought, are regretted. It is refreshing to your President, therefore, to see the "cooler thought" prevail before rather than afterwards.

In the trouble and turmoil of the past few years, you have seen many old maxims, many time-tried truths swept into the discard, and untried theories adopted in their place. The members of the 1935 House of Delegates of the California Medical Association have shown by their actions that the old maxim, "United we stand, divided we fall," still serves as a guide.

Your President knows only too well, and appreciates only too thoroughly, just how many heartaches were incurred, and how much self-sacrifice was accepted, by individual members at Yosemite, in order that the best interests of the medical profession might be served. He is immensely heartened by this evidence of devotion while, at the same time, he sorrows at its cost. He has increased confidence in the future, and is encouraged by the increasing evidence of the solidarity of the profession. Let us continue this evidence of coöperation and harmony. Your President is at your service.

Cordially and fraternally,

ROBERT A. PEERS, *President.*

SIDELIGHTS ON THE YOSEMITE ANNUAL SESSION

DINNER TO PRESIDENT CLARENCE G. TOLAND

The dinner tendered to President Clarence G. Toland was held on Tuesday evening, May 15, in Camp Curry Pavilion at Yosemite National Park. The dining-hall filled rapidly with the twelve hundred members and guests who had gathered to do honor to the retiring president. In spite of the handicaps incident to caring for so large a group in advance of the regular Park season, and at a time when many of the Park personnel were still becoming acquainted with their respective duties, the dinner was served with dispatch. It early became evident, from the general hum of conversation and laughter, that the members and guests had responded to the beauties of Yosemite Valley in full measure, and that with extra attractions such as the firefall, which was postponed from nine to the nine-thirty hour, the after-dinner speeches, even though scheduled on the menu cards as being each of only five minutes' length, would be more in the nature of gestures than of performance. And so it turned out to be. Toastmaster Kress, in order to make himself heard, made megaphonic efforts to reach all parts of the pavilion, but with only faint success. The humor of the situation appealed to all, however, and the speakers, as they were announced, received welcoming rounds of applause, although their kindly expressions were heard by only a few who sat close to the speakers' table. Council Chairman Kelly was equal to the occasion, and gave his speech in the sign language. Immediately after dinner the guests adjourned to witness the spectacular firefall, after which the light fantastic was tripped in the adjacent dancing pavilion.

Excerpts from the printed menu cards follow:

CALIFORNIA MEDICAL ASSOCIATION

SIXTY-FOURTH ANNUAL MEETING

YOSEMITE NATIONAL PARK

MAY 13-16, 1935

PRESIDENT'S DINNER

Honoring President Clarence G. Toland, M.D.

"Five Minute Courses"

J. S. MC LESTER, M.D.
President-Elect, American Medical Association

"Titles of honor add not to his worth
Who is to himself an honor to his titles."
Lady's Trial, Act I, Sc. 3

E. STARR JUDD, M.D.
Past President, American Medical Association

"A great man is made up of qualities
That meet or make great occasions."
Study Window—Lowell

ROBERT A. PEERS, M.D.
President-Elect

"An honest man, close-buttoned to the chin,
Broadcloth without, and a warm heart within."
Cowper

T. HENSHAW KELLY, M.D.
Chairman of the Council

"He mouths a sentence as curs mouth a bone."
The Rosciad, L. 322

PRESIDENT CLARENCE G. TOLAND, M.D.

"He hath a heart as sound as a bell
And his tongue is his clapper,
For what his heart thinks his tongue speaks."
Much Ado About Nothing, Act III, Sc. 2

ENTERTAINMENT

"To mourn a mischief that is past and gone
Is the next way to draw new mischief on."
Othello, Act I, Sc. 3

PARK STROLLERS—

As and when you see them during dinner.

FIREFALL FEEDING BEARS

DANCING

"Most glorious night!
Thou wert not sent for slumber."
Don Juan, Canto II, St. 152

?

"Diverse men have diverse recreations and exercises."
Burton, Anatomy of Melancholy

MENU

"O hour of all hours, the most bless'd on Earth,
The blessed hour of our dinners."
Lucile, Pt. I, Canto II, St. 23

Fruit Cocktail

Green Olives Crisp Celery Hearts

Consomme, Julienne

Poached Salmon with Egg Sauce

Sirloin Steak with Mushroom Sauce

Potatoes au Gratin Buttered New Peas

Mixed Green Salad with French Dressing

Hot Dinner Rolls

Biscuit Tortoni

Demi-tasse

Camp Curry, Yosemite National Park - - May 14, 1935

LUNCHEON OF THE COUNTY SOCIETY SECRETARIES

President-elect Peers presided at the combined state and county officers' luncheon, which was held at the Ahwahnee Hotel in the Yosemite Valley, Wednesday noon, May 15. There were present most of the councilors and state officers and several officers of the component county societies.* Following introductory remarks by the president-elect, short addresses were given by many of those present, including President Toland, who outlined the work of the past year and paid tribute to the work of the councilors and to Secretary Warnshuis; General Counsel Peart, who discussed legal matters of interest to the component county societies, and warned of the pitfalls which await the unwary who proceed without proper legal advice; Dr. J. B. Harris, who sketched legislative problems and difficulties which confront organized medicine, as seen by the chairman of the Legislative Committee; and Dr. C. A. Dukes, who spoke on the present and contemplated activities of the Department of Public Relations.

At this point Past President O. D. Hamlin, who arrived late, was tendered a warm greeting by those present.

Dr. F. C. Warnshuis, secretary-treasurer and director of the Committee on Public Relations, explained how the state office can serve the county officers and the individual members of the medical profession. He urged all county officers to call upon the central office of the Association at any and all times, and to carry back to their members the message, that he and the personnel of his office are willing and anxious to be of service at any and all times. Secretary Warnshuis then presented Mr. Milton Silverman, who has been serving the society as publicity agent for the past two months.

Brief discussions by Seeretary Moore of the Alameda County Medical Society, Doctor Striekler, first vice-president of the San Francisco County Society, Doctor Butler of Sonoma, Doctor Cushman of Mendocino County, and others, followed. The meeting was closed by remarks from the editor, Dr. George H. Kress.

It was the general opinion of all present that the importance of meetings between the state officers and the officers of the component county societies has not been sufficiently stressed. It was generally agreed that, instead of being merely a secretaries' luncheon, it should be a luncheon to all county officers. The value of such meetings in promoting a better understanding by the members of the California Medical Association,

* Present were eighteen state officers and seventeen officers of component county societies.

through the county society officers, of the responsibilities and activities of the state officers, and in providing an equal opportunity for the officers of the California Medical Association to become better acquainted with the needs and problems of the county societies, was particularly stressed. Also, Doctor Warnshuis' suggestion for a mid-winter meeting of the officers of the California Medical Association and the officers of the component county societies where such problems could come up for discussion, received much favorable comment. R. A. P.

* * *

FIRST ANNUAL REUNION OF PAST-PRESIDENTS

This, the first of what it is hoped will become an annual reunion of the past presidents of the California Medical Association, was initiated by an informal breakfast in the alcove of the main dining-room of the Ahwahnee Hotel at 7:30 o'clock on the morning of May 14. By direction of the Council, President-elect Robert A. Peers presided. Of the eleven past presidents in attendance at the annual convention, nine, or 82 per cent, attended. In addition to the following past presidents, George H. Kress (1917), C. Van Zwalenburg (1919), John H. Graves (1922), Edward N. Ewer (1926), William H. Kiger (1927), Lyell C. Kinney (1929), Morton R. Gibbons (1930), Junius B. Harris (1931), and George G. Reinle (1933), the following invited guests were present: Dr. James S. McLester, president-elect of the American Medical Association, and Dr. C. G. Toland, president of the California Medical Association.

Following the breakfast, Chairman Peers stated that many members of the Council at the convention held in Riverside, feeling that we could ill afford to lose the benefit of the experience and counsel of our past presidents, and realizing also that some recognition should be extended them for their previous services, were moved to instruct the secretary to arrange for a meeting of our distinguished former officers at some time during the 1935 session. In accordance with these instructions, Secretary Warnshuis arranged the Tuesday morning breakfast.

After stating that he hoped this would become an annual event and that out of the meeting there would grow a permanent organization to be known, perhaps, as the "Past Presidents' Club," the chairman introduced Dr. James S. McLester, president-elect of the American Medical Association, who delivered a greeting from that body, and spoke briefly upon the subject of medical economics.

Following Doctor McLester's remarks, there were addresses by each of those present, commencing with the senior past president present, Doctor Kress, and then the junior past president, Doctor Reinle, and President Toland. Everyone reiterated the hope of the chairman, that the meeting would result in the formation of a permanent organization.

The undersigned looks forward with pleasant anticipation to the reunion in Coronado in 1936, and hopes that there may be a record attendance of 100 per cent.

Robert A. Peers.

* * *

MÉLANGE

The following observations are intended to impart to non-attendants a few of the outstanding features that characterized the Yosemite session. They reflect some of the fraternal and social activities that enhance the attractions of our annual sessions and are not recounted in the official minutes.

* * *

An orchestra of fifteen pieces played California and popular music while the audience was assembling for the opening general session. At the hour of 10 a. m. on Monday morning when some 900 members were assembled, President Toland introduced Mrs. Fred B. Clarke of Long Beach who led the audience in singing "I Love You, California." By her gracious compliment to President Toland with her cultured voice, Mrs. Clarke fixed the keynote of the entire session—good fellowship and genial camaraderie.

At the President's Dinner on Tuesday night, 1,138 were served in the main dining room. There was an overflow of 235 in the Ahwahnee dining room and over 600 were served at Yosemite Lodge. Doctor Kress, as toastmaster, was in his customary efficient fettle. During the dinner Doctor Barnard of Los Angeles supplemented—no, exceeded the Park Strollers—by his artistic renditions on the accordion. "Barney" is appointed as master of ceremonies at the 1936 Coronado meeting. Would we could describe the ladies, their gowns and charms. Surely was a style show and a lovely moonlight night. All too soon the dance orchestra "signed off."

* * *

Doctor Don Tressidor, president of the Ahwahnee Curry Company, Manager Goldworthy, Assistant Manager Rossington—in fact, all of the Park's official family were indefatigable in seeking to supply every want.

* * *

"This night was not made for slumber"—so the president's program read. Just 1,600 agreed.

* * *

Woman's Auxiliary—certainly the session would have been somewhat quiet were it not for their inspiring initiative. California medicine needs, yea requires, such feminine inspiration. Every acknowledgment is made for their coöperative assistance.

* * *

The last paper on Thursday afternoon in the Surgical Section held an audience of fifty members. In its two sessions the House of Delegates devoted nine hours in deliberating association problems and policies. Reference Committee Nos. One and Two devoted all of Tuesday and Wednesday in hearings, reviewing reports and drafting recommendations. Every member is indebted to these delegates for their unselfish and untiring service. Watch for the July issue which will contain the minutes, and be sure to read them.

* * *

The Council held five sessions, the Department of Public Relations, two.

* * *

Much credit is due the officers of the Woman's Auxiliary for the splendid programs of that organization and for their aid in the social functions. Mrs. Loren Chandler broke the golf course record for women. Her card of twenty-six was certified to by "Yank."

In spite of ten feet of snow on Glacier Point, 4,000 feet above the floor of the valley, the Park management put on the "Firefall" every night, a beautiful spectacle.

* * *

Many members failed to take the trouble to register—our estimate of attendance, 1,600, is based on hotel and camp reservations.

* * *

The Cancer Commission Conference on Sunday morning was attended by forty-seven members. This conference is an important feature of the program and is creating more interest each year.

* * *

Our sixty-fourth annual session is now a matter of record and a memorable occasion for those who attended. Plans are already underway for our sixty-fifth session. Coronado in 1936 is now our watch-word. Plan to attend. F. C. W.

STATE AND COUNTY SOCIETY ACTIVITIES

SIXTY-FOURTH ANNUAL SESSION

In Yosemite National Park, midst a setting of nature's making, our Association held its sixty-fourth annual session on May 13-16, under the presidency of Clarence G. Toland.

On Sunday, May 12, under the auspices of our Cancer Commission, some fifty-one members engaged in a Pathological and Radiological Conference. The Council held its first meeting Sunday evening.

Beginning with the opening general meeting to the last session on Thursday afternoon, some 1,600 members and their friends were participants in the scientific and social programs. Had accommodations been available, a registration of 2,500 would have been recorded.

The official minutes will appear in the July issue. Advance announcement is made, however, of the following elections:

President-elect—Edward M. Pallette of Los Angeles.

Speaker of House of Delegates—William W. Roblee, Riverside.

Vice-Speaker of House of Delegates—John H. Graves, San Francisco.

Chairman of Council—T. Henshaw Kelly, San Francisco.

Secretary-Treasurer and Director of Public Relations—F. C. Warnshuis, San Francisco.

Editor—George H. Kress, Los Angeles.

Councilors—First District, C. L. Emmons, Ontario; Fourth District, A. E. Anderson, Fresno; Seventh District, O. D. Hamlin, Oakland; Councilors-at-Large, Harry H. Wilson, Los Angeles; Morton R. Gibbons, San Francisco.

American Medical Association Delegates—Elbridge Best, San Francisco; Lyell C. Kinney, San Diego; Fred B. Clarke, Long Beach.

American Medical Association Alternates—Robert S. Stone, San Francisco; Harry H. Wilson, Los Angeles; A. J. Scott, Los Angeles.

Coronado was chosen as the 1936 meeting place.

The California American Medical Association delegates were unanimously instructed to place in nomination the name of Dr. George H. Kress for the vacancy on the Board of Trustees of the American Medical Association. Watch for the July issue for complete details of this annual session.

* * *

DELINQUENTS

By-Law provisions prescribe that every member whose current dues remain unpaid on April 1 shall be placed on the suspended list. Such a member loses all of his membership benefits and his name is removed from this publication's mailing list. Reinstatement may be obtained by paying the annual dues to the county secretary.

On April 1, this year, 890 members became suspended. Since then 184 have been reinstated. County secretaries have been commendably diligent in collecting and remitting dues. They can render additional service by calling upon their delinquent members and inviting them to reinstate themselves.

Out of some 10,000 physicians in the State, 5,159 are affiliated with their county and State organizations. It is estimated that there are some 1,500 physicians eligible for membership who are not members. The Council invites every member to make an effort to secure the affiliation of these non-members. Urge your fellow physician who is not a member to join his county society in order that our Association may represent at least 80 per cent of the eligible physicians in California.

* * *

THE NEED OF A WOMAN'S AUXILIARY

A number of the members of the medical profession, particularly those who have not been active in the organization field, have expressed doubt as to the need of a Woman's Auxiliary to organized medicine. To those who carry the burden of the duties of office, there comes a realization that there is a necessary and vital place which the wives of doctors can fill.

In these days of changing social conditions and the development of a new social philosophy, there must be created some link or liaison between our organized units and society in general.

The busy doctor does not have the time to make necessary contacts with various legislative bodies, with the press and with all the numerous organizations that exist in any given community. These groups are interested in the problems of medicine and we doctors should be interested in their problems. We are often condemned for our narrowness of community vision. We have failed often to present to the community our work, our beliefs, our policies and our standards.

Each county society needs an auxiliary for this definite community objective—rather than for social purposes. Persons eligible for membership are: Doctors' wives, mothers, sisters, and daughters.

We invite the interest of doctor's wives so that they may be auxiliary not only to the medical profession but also to the public.

* * *

AMERICAN MEDICAL ASSOCIATION ECONOMIC CONFERENCE

At the February special meeting of the American Medical Association House of Delegates a resolution was adopted directing the Bureau of Economics to study and devise a plan or plans that would enable county and State units to provide medical care to certain groups of people and to submit a report at the June meeting of the American Medical Association.

The executive officers and the director of the Bureau of Economics issued a call for a conference to be held in Chicago on April 27. Some twenty-five states were invited to send representatives. Such an invitation was received by the California Medical Association. Our Executive Committee appointed Dr. Benjamin Black of Oakland as California's representative. By request Doctor Black has prepared the following general report. Further reports will appear in *The Journal of the American Medical Association.* Our members are indebted to Doctor Black for his time and services and expressions of appreciation are hereby recorded. Doctor Black's report follows:

To the Executive Committee of the California Medical Association:

I received Secretary Warnshuis' note of April 29, 1935, this morning just after my arrival home. The trip was pleasant. I left here as scheduled on Thursday evening, arriving in Chicago late Friday afternoon and left there last night at 6:15 p. m., reaching here before 9 a. m. this morning. It was a rather difficult trip but it does permit one to cover territory in record breaking time.

There were probably twenty-five physicians representing as many county or state societies and a number of lay secretaries representing such associations in attendance. In addition, Doctor Bierring, president of the Association, Doctor West, Doctor Fishbein, Doctor Hayden and others spent part of the time with us. The conference convened rather promptly at 9:30 a. m. under the chairmanship of Dr. R. G. Leland and continued until about 5:30 p. m. in the afternoon, running through the noon hour, as we all had luncheon together. The conference was rather well planned and it began with a free discussion of the various medical plans including special fee schedules that have been adopted, plans for the care of the indigent, particularly the Iowa plan, whereby specified sums are paid quarterly through the county medical society from the particular unit of government having to do with indigents; also plans having to do with pre-payment of medical care where medical service bureaus had been set up as in Fulton County, Georgia, largely covering the practice in Atlanta; likewise the hospital association plans in the State of Oregon and similar plans being worked out by the State of Washington. A formal presentation of the plan recently adopted by the District of Columbia was presented by Doctor Wilson and Mr. Garrett. The Wayne County, Michigan, plan was presented, as were all sorts of minor activities classified under the names of plans by various other persons speaking for county societies. This included, as you will appreciate, the regulations governing clinic and dispensary admissions, the manner of handling emergency relief to physicians, and other allied activities in which county societies formally participated.

I was invited to present the Alameda County Plan which I did informally, but left a rather carefully prepared state-

ment of the plan and its operation for the purpose of record. I also presented in less detail the San Diego County Plan, and made reference to the work being done in San Joaquin County, Fresno County, and Los Angeles County, particularly the so-called San Fernando Plan.

I left with them such information as I had covering more detail than the discussion would permit.

One was impressed with the fact that from the reports it would appear that almost every type of service is being supplied through county medical societies from an admission bureau which also handles pre-payment and post-payment of medical bills as found in the District of Columbia to frank voluntary periodic payment basis plans as found in Atlanta, Georgia. The officials of the American Medical Association seemed very anxious to secure all of this information. There was no critical attitude manifest against any of the proposals submitted and the entire conference freely discussed each proposal as it was submitted, asking questions for purposes of enlightenment with an apparent intense desire on the part of each to understand the movement which seems to be going on throughout the country.

It was proposed in the general discussion that the office of the American Medical Association would digest these various proposals for the purpose of making a submission to the House of Delegates in June. It became evident in the conference that the American Medical Association could not rightfully adopt any plan with the idea of standardizing such an activity in all the counties covered by the Association. The conference passed but one resolution which in effect stated that plans now in operation by county societies or that were contemplated, should comply with principles adopted by their respective State Associations which in the annunciation of principles would follow the general policy laid down by the American Medical Association.

In addition to the ten principles adopted by the House of Delegates in Cleveland in 1934 for the guidance of county medical societies in the conduct of medical service experiments, it was recommended that the following principles be incorporated for any society that contemplated the development of a plan for local application:

1. That a preliminary study be made to determine the necessity or need for any change.
2. That the patient should have freedom of choice of physician.
3. That the plan should be completely controlled by the county medical society. This did not require that all the officials conducting the plan should be physicians, but that sufficient physicians should be on boards of directors or otherwise in control to write the policy.
4. That medical fees for low income groups should be based on ability to pay rather than minimal fee schedules.
5. That there should be a definite plan for a fair determination of the patients' ability to pay.
6. That there should be some centralized system of records and bookkeeping.
7. That any plan should contemplate complete medical service.
8. That the administration of any plan should provide for a service charge for operation of office and should also provide reserve for emergencies or catastrophic loads.
9. That there should be recognition of standing of medical specialties and resistance to exploitation by corporations of any type.

There was presented to each member of the conference a suggestive outline relative to the preparation of a medical society plan covering in some detail these points.

It is my own opinion that the conference was very valuable; that it allowed, perhaps, for the first time, a complete and full discussion of the various so-called plans in operation. I profited greatly. My own participation was well received and many comments were made upon *all* of the medical activities in California, particularly the Alameda County Plan as presented, the standards adopted by the State Association, and there was considerable discussion relative to the proposed compulsory insurance bill now pending before legislature.

B. W. Black, M. D.,
Representative for California.

* * *

POSTGRADUATE CONFERENCES

The second postgraduate session in our course was held at Riverside last night and it was a complete success notwithstanding the fact that the Southern California Medical Association held a two-day session last Friday and Saturday at Arrowhead Springs and the State meeting coming next week. We had over a hundred men in attendance.

Some good clinical material was supplied and the instructors made good use of their opportunity. I would strongly urge other societies undertaking such a course to insist that the teaching be clinical rather than didactic. Our Riverside meeting was a distinct improvement over the San Bernardino one where cases were not furnished.

Very truly yours,
W. W. Roblee, M. D.

AMERICAN MEDICAL ASSOCIATION MEETING

The annual meeting of the American Medical Association will be held in Atlantic City the week of June 9. The following California Fellows appear on the scientific program: Melverton E. Trainor, Los Angeles; Maurice L. Tainter, San Francisco; Windsor C. Cutting, San Francisco; Andrew B. Stockton, San Francisco; E. Hines, San Francisco; Paul D. Foster, Los Angeles; William E. Stevens, San Francisco; John C. Wilson, Los Angeles; Pierre J. Walker, Los Angeles; F. L. Reichert, San Francisco.

* * *

PHYSICIANS' CONTRIBUTIONS OF SERVICES

The Council has directed that information be obtained that will disclose the sum of money represented by the services that are being rendered by physicians on the staffs of county hospitals. These doctors receive no remuneration for their services to the patients in county hospitals. They are rarely given recognition for their services by those in control, and the public does not know that no payment is made to the attending and visiting physicians. It is felt that the public should be informed.

A questionnaire covering the subject was sent some two months ago to every county society for the urpose of securing this information. To date fifteen questionnaires have been returned. While not wholly accurate and in some instances incomplete (because no records are kept), the returns supply a general insight as to what the profession is contributing in services for which they receive no returns. The following figures deal with fifteen counties and do not include San Francisco. They do include Alameda and Los Angeles counties.

Cases admitted to county hospitals	109,669
Out-patient departments	736,744
Operations performed	45,130
Surgical fees equivalent	$2,749,222.00
Medical visits equivalent	$574,323.00
Medical clinical equivalent	$433,345.00
Obstetrical fees equivalent	$55,300.00
Total services in fifteen counties	$4,509,450.00

These figures are based on fifty-cent clinic visits, two-dollar medical visits, and an average charge of $50 for operations.

Annual reports of hospital boards and officers stress in considerable detail the services rendered by their hospital. Scant and often no reference is made, nor is recognition given to the services rendered by the attending staff. This is an injustice. It should be remedied. The suggestion is made that hospital staffs draw attention to this fact and respectfully request the hospital management to prominently acknowledge to the public the services and its value that the medical staff is contributing to the county.

While this comment relates to county hospitals it also is pertinent to private hospitals admitting non-paying patients. Contribution in services by physicians in almost every community exceeds the public's contributions to Community Chests—often threefold. Cite these figures to your hospital management in order that full credit may be given where credit is due.

* * *

PUBLICITY

The development of sound public opinion in regard to scientific and preventive medicine is one of the responsibilities of county and state medical organizations. Much of the public's misconception in regard to disease and treatment is largely due to misinformation.

During the past three months the Secretary's office, through the Association Publicity representative, Mr. Silverman, has been releasing four articles a week to some 250 California newspapers. These releases consist of 200 to 300 words that set forth accepted facts regarding diseases, treatment, or preventive measures. The public is being furnished with dependable facts.

Clipping returns indicate a wide publication of these releases. Many personal inquiries from lay people have been received; one day there were seven such

inquiries. The following letter reveals that which is being accomplished by this publicity activity:

To the California Medical Association:

Through the press, I have been informed of a discovery made by a member of your organization for the growing of undeveloped children through the use of insulin injections.

The doctor of my boy, who is very small for his age, is very much interested in this matter and has asked me to write you as he does not know English. He would be very much obliged if you would send us details of the treatment and results you have obtained.

I am writing you by air mail and beg you to reply the same way and I will gladly refund the postage or any other expenses.

Thanking you in advance, I beg to remain,

Yours very truly,

S. E. Altamirano.

Address: Salvador E. Altamirano, Convención 1220, Montevideo, Uruguay.

* * *

AUTOMOBILE ACCIDENTS

In 1934 some 36,000 persons were killed and nearly a million injured by reason of automobile accidents. This is an increase of 16 per cent over 1933. Speed is credited as the greatest factor. Of the drivers involved, 3.16 per cent are reported as being intoxicated. Five out of every eight pedestrians killed were involved while crossing in the middle of the street, crossing against signals, or darting from behind cars.

Bill Holman proffers the following suggestions:

Check the wheel; make sure that a loose nut is not holding it.

Do not race trains to crossings. If it is a tie, you lose.

Beware of "green" drivers on red lights.

If you must have a blowout, have it at home.

A pedestrian is a man who missed the payments on his car.

A wheel in the hand is worth two in the head.

As the sun goes down, cut your speed.

Every automobile driver must be made to become a safe and sane driver. Doctor, you can set an example.

* * *

WORTH PONDERING OVER

The borderline 'twixt faith and fanaticism is indistinct. Likewise, that between salutary self-interest and sordid self-indulgence.

* * *

Cynicism subtly employed, is often mistaken for argument.

* * *

"Facts" are less stubborn than are the self-deceived who claim to be in possession of them.

* * *

There is in existence a slogan, "Look up not down, look out not in, look forward not backward, and lend a hand."

This may be modernized as follows:

Look out to avoid danger.

Look in before denunciations of others or approbation of self.

Look up if studying the stars or watching for an airplane.

Look down when negotiating a perilous trail.

Look forward, as a rule, lest one should inadvertently bowl over an approaching pedestrian, but glance backward from time to time if you reside in Washington, Chicago, or Sacramento, and lend a hand to the deserving.

* * *

"We see in the future a dawn of brighter hope for mankind, of better health for men and women, of happy, sturdy growth for little children. Toward this dawn that is to come, the men of medicine and scientists are moving; the thousand of research workers in their practices and clinics. With endless patience and devotion they search, in many lands, but with a united purpose, that mankind may have life more abundantly. In the field of preventive medicine alone, they have brought us marvelous victories—victories over typhoid and scarlet fever, diabetes, diphtheria, smallpox, yellow fever. And in this future dawn, man shall live in joyful health and vigor through his full span of life by reason of the services rendered by the scientific man of medicine."

* * *

Axioms of yesterday fall before the revelations of today.

MINUTES OF THE HOUSE OF DELEGATES

ANNUAL REPORT OF THE COUNCIL*

Mr. Speaker and Members of the House of Delegates:

The Council submits this report, transmitting to the House of Delegates the principle features of the work of the Council and of the Association during the year 1934-1935.

An extraordinary demand has been made upon the Council during the past year by the many unusual matters that have arisen that have had to be met by the best efforts of this Council. Nine meetings of the Council have been held during the year instead of the customary two or three sessions. The minutes of these meetings have been published in California and Western Medicine and are part of this report.

Some of these matters with which the Council has had to deal will be taken up seriatim and with the recommendations that the Council makes to this House of Delegates.

The Committee of Five.—The Committee of Five, created by the 1934 session of the House of Delegates at Riverside, is conducting a very comprehensive survey of the economic aspects of illness in California.

In coöperation with the California State Board of Health some $86,000 was secured from the SERA for field work and certain types of office work. The Council, in obedience to the resolution creating the Committee of Five, appropriated $32,750 for the work of the committee, necessary for the effective supervisorial investigative and skilled statistical work required for the proper conduct of the survey.

Preliminary and supplementary reports were submitted by the Advisory Economic Council and the Survey staff to the special session of the House of Delegates on March 2, 1935, at Los Angeles. At this session the Committee of Five also presented a majority report signed by four members, and a minority report signed by one member.

Because of delay, not within the control of the Council or the Committee of Five, the completion of the survey was not attained before the opening of the 1935 Legislature. After a joint meeting of the Senate Interim Committee, the Committee of Five and the Council on January 19 and further communication with the Senate Interim Committee, based upon discussions had at the aforesaid meeting, the Council called a special session of the House of Delegates to meet at Los Angeles on March 2 and 3, 1935.

The purpose of this meeting was to express an opinion upon health insurance in California, based upon the material then available from the survey and the report of the Committee of Five. The necessity for this expression was created by the fact that the Senate Interim Committee was required to make its report to the Senate and was anxious for such expression from the California Medical Association.

In order that a maximum representation of the component county societies might be had for the expression of the Association's attitude upon health in-

* The report of the Council was not printed in the "Pre-Convention Bulletin" of the April issue, in order that the status of legislative and other matters as of the date of the Yosemite annual session might be noted. The complete minutes of the House of Delegates will be printed in the July issue.

surance, the Council, following the lead of the American Medical Association at the special session of its House of Delegates in Chicago in February, 1935, defrayed the travel expenses of the delegates from the funds of the Association.

The action of the House of Delegates upon the majority and minority reports of the Committee of Five, which reports were published in the minutes of the meeting of the House of Delegates, is known to all and resulted in the creation by resolution of the Committee of Six, charged with the task of coöperating with the Senate Interim Committee and of safeguarding health insurance legislation according to the principles set forth in that resolution.

The report of that committee will be made by the committee to the House of Delegates.

Initiatives Nos. 9 and 17.—The chiropractors and naturopaths succeeded in placing upon the ballot, in November, 1934, two initiatives which would have given them almost unlimited rights in the practice of medicine in public institutions, etc. They brought every effort to bear to pass these.

It was only by the most intensive effort and the use of speakers, handbills, letters, radio and all obtainable newspaper publicity that the initiatives were decisively defeated at the polls.

The Council considered very deeply the import of these initiatives and concluded that every resource of the Association must be used for their defeat.

In pursuance of this purpose, $14,500 was expended for radio time and various types of literature for distribution. In this matter the Council received the valuable and effective coöperation of the Public Health League of California and expressed its thanks to that organization.

Other Legislation.—The subject of legislation at the 1935 Legislature will be covered in the report of the Committee on Public Policy and Legislation, Junius B. Harris, chairman. Other phases will be contained in the report of the General Counsel.

Legislation in Relation to Voluntary Health Insurance.—The Council believes that in looking to the future of medical practice in the State of California, the House of Delegates must consider the possibility that compulsory health insurance legislation may not be passed at the present session of the legislature.

The Council believes that the House of Delegates, at this session, should consider whether the Association should seek passage of a bill, by proper amendment, to provide a means whereby a voluntary system of health insurance might be instituted in California by component county societies or the California Medical Association if public demand render it desirable to do so.

In order to bring this matter before the House of Delegates for discussion, if it so desires, the Council presents the following resolution:

WHEREAS, At some later date, the California Medical Association or some of its component county societies may desire to develop plans for voluntary hospital or complete health insurance; and

WHEREAS, At the present time the laws of California make this development very difficult and at the same time provide no direct control of such practice; therefore be it

Resolved, That the Council of the California Medical Association is hereby instructed to secure, if possible, the passage of a bill providing, in the opinion of the Council, for the proper development and safeguard of voluntary health insurance plans in California.

Secretary-Treasurer.—On October 1, 1934, Dr. Frederick Cook Warnshuis assumed the office of secretary-treasurer, Dr. Emma W. Pope having resigned after eleven years of devoted and untiring service to the Association.

Dr. Benjamin Black of Oakland having been offered the position and because of good and sufficient reasons having had to decline it, it was found that Doctor Warnshuis, long-time secretary of the Michigan State Medical Society and Speaker of the House of Delegates of the American Medical Association, was available. After consideration, and in view of the mass of work confronting the office of the Association dealing with the approaching initiatives, health insurance, and other medico-economic problems, making a wide experience a very valuable asset to the Association, Doctor Warnshuis was offered the positions of secretary-treasurer and Director of Public Relations and accepted.

He has made numerous contacts with various component county societies and has carried the office of the Association through the busiest time of its existence smoothly and efficiently.

When the press of the legislation is done, he will visit all of the remaining county societies and their officers so that an invaluable personal contact will exist between the offices of the Association and all of its component county units.

Finances.—The expenditures of the Association this year have been unusual and large, and have cut deeply into its reserves.

While health insurance, the survey of the Committee of Five, and Initiatives No. 9 and No. 17 accounted for most of the expense, it is evident that the Association cannot continue on an unchecked course of expenditure such as has characterized the past year.

The Constitution and By-Laws protect the funds of the Association from undue expenditures upon the part of individual officers. The Council suggests that serious thought be given by the House of Delegates before any further expenditures, unknown in amount at the time, are authorized by the House of Delegates outside of the usual control provided by the Constitution and By-Laws and that the House go on record as supporting the Council in any future refusal to assume obligations of actions begun by members or component county units of the Association without consultation with or permission of the House of Delegates or the Council of the Association.

Needless to say, the Council considers the reëstabment of the 1933 financial status of the Association funds of prime importance and calls the attention of the House of Delegates to the necessity of further calls upon the reserve funds of the Association now held by the Trustees Of The California Medical Association, a corporation, to defray expenses of the Association in 1935.

Budget.—The Council submits the following budget for the approval of the House of Delegates, it having been submitted by the Auditing Committee, approved by the Executive Committee and the Council:

BUDGET—1935-1936

Estimated Income:	
1. Membership dues—5,200	$52,000.00
2. Earned interest	100.00
3. Herzstein bequest	750.00
4. Advertising income	20,000.00
5. Commissions	500.00
6. California and Western Medicine subscriptions	500.00
7. Reprint sales	1,500.00
8. Sales of books	180.00
9. Estimated income	$75,530.00
Estimated Expenses:	
10. Public Relations	$ 1,000.00
11. Postgraduate work	1,500.00
12. Legislative expense	4,400.00
13. Committee expense	1,000.00
14. Legal expenses	6,000.00
15. Fair exhibits	1,000.00
16. Annual meeting	1,000.00
17. Delegates, American Medical Association	1,500.00
18. Woman's Auxiliary	150.00
19. Council travel expense	750.00
20. Executive Committee travel expense	500.00
21. Printing California and Western Medicine	20,000.00
22. Editor's salary	4,000.00
23. Journal assistance	2,800.00
24. California and Western Medicine miscellaneous	500.00
25. Rent	3,500.00
26. Telegraph	300.00
27. Stationery supplies	1,000.00
28. Postage	750.00
29. Office supplies	250.00
30. Express and cartage	100.00
31. Stenographic services	6,000.00
32. Travel expense	1,200.00
33. Office files	250.00
34. Director Public Relations' salary	4,000.00
35. Secretary's salary	6,000.00
36. Publicity estimate	3,000.00
37. Reserve	6,080.00
38. Estimated expenses	$78,530.00

EXPLANATORY STATEMENT CONCERNING BUDGET

1. It is estimated that by a persistent campaign and individual correspondence we can bring membership up to the 60 per cent standard of the country.
2. Because of depleted reserve the interest earnings may not equal this amount.
4. There is good reason to believe that advertising income may be increased. Advertising is being resumed and now accounts are obtainable.
5. From the Coöperative Medical Advertising Bureau.
6. By eliminating certain exchanges subscriptions will be increased.
7. Earnings obtainable from Reprint sales.
9. Gross income of at least $75,530 is a reasonable estimate.
11. To cover expenses of Extension Lectures, Postgraduate Council District conferences.
12. Self-explanatory.
13. To cover printing and expenses of all Standing Committees.
14. Self-explanatory. May be less, if extra legal services are not required.
15. Equals expenditures of 1934.
16. Arbitrary amount. If the estimated sale of exhibit space is realized there will be a profit and not an expense for the annual meeting.
17. Increased because the American Medical Association meeting is in Atlantic City.
18. Auxiliary request.
19 and 20. These two amounts should cover travel expenses of Council meetings and monthly Executive Committee meetings.
21. Printing cost is on basis of 1934.
24. For feature issues and to cover binding, stationery, telegrams and similar editorial and business expenses and binding volumes.
25. Under terms of executed lease.
27. Stationery, membership certificates, county report blanks, envelopes, etc.
28. Includes all correspondence of all departments, mailing certificates and lay correspondence.
31. Present schedule.
32. Secretary's State travel to county societies, Council meetings, postgraduate conferences. Items to be approved as to amount in each instance by Auditing Committee.
33. It is purposed to build a Reference Library so as to have immediately available reference facts, thereby obviating writing to the American Medical Association and State organizations and delay while waiting for replies. Cost will be for files and reference indexes and classification.
36. This is an estimated reserve that will be increased in amount as savings are made in the appropriated items. The Association should plan to place about 10 per cent of its gross revenue into reserve and so rebuild its assets which have been expended this year in two major activities.

Note.—No expenditures will be incurred when the individual appropriations are expended. Additional expenditures must await action by the Council, upon recommendation of the Auditing Committee.

Dues.—The Council recommends to the House of Delegates that the dues for the year 1936 be set at the present amount of $10.

Legal Department.—The Council, by resolution on December 22, 1934, created a committee to survey the legal activities and expenditures of the Association for the preceding five years. This committee consisted of Doctors Roblee, Kiger and Gibbons, and after a thorough study it submitted the following report which, with its recommendations, is made a part of this report.

This report was printed in California and Western Medicine, April, 1935, page 321.

Maternal Welfare.—The American Committee on Maternal Welfare, Incorporated, is an outgrowth of a Joint Committee on Maternal Welfare established many years ago by action of the American Child Health Association, asking coöperation of the American Gynecological Society, the American Association of Obstetricians and Gynecologists, and the Section on Obstetrics and Gynecology of the American Medical Association, in the formation of a joint committee to promote the cause of maternal welfare.

The organizations represented by the present American Committee on Maternal Welfare are:

American Association of Obstetricians, Gynecologists, and Abdominal Surgeons.
American Child Health Association.
American College of Surgeons.
American Gynecological Society.
Section on Obstetrics and Gynecology of the American Medical Association.
American Public Health Association.
Central Association of Obstetricians and Gynecologists.
Chicago Maternity Center.
Children's Bureau, Department of Labor.
Maternity Center Association of New York.
Pacific Coast Society of Obstetrics and Gynecology.
Southern Medical Association.

The major program of the committee now is to secure the formation of committees in all of the states for the furtherance of maternal welfare.

The American Committee has one of two plans in view:

First: The formation of a committee by each state society in the American Medical Association; and failing of this in any state, second, the appointment by the committee of members in a given state to form a committee to further the development of a maternal welfare program.

In the opinion of the Council, the first method is the desirable one because the development of a maternal welfare program will be in the hands of the California Medical Association, in coöperation with the American Committee on Maternal Welfare, instead of in the hands of a committee responsible only to a national organization other than the American Medical Association.

Unquestionably, the advancement of maternal welfare is a matter which can well receive the attention of the California Medical Association, and in furtherance of the plans proposed by the American Committee on Maternal Welfare the Council recommends the adoption by the House of Delegates of the following resolution:

Whereas, The American Committee on Maternal Welfare, composed of representatives from the various professional and social organizations in the United States interested in increasing maternal care and the reduction of maternal and infant mortality, has embarked upon an extensive program in the United States; and

Whereas, There can be no question that the work contemplated by this committee is desirable and, if effectively carried out, will result in great benefit to both the public and the profession; and

Whereas, In the opinion of this House of Delegates, the work can best be done in California by the coöperation of the California Medical Association with the American Committee on Maternal Welfare; therefore be it

Resolved, That a committee of five members of the California Medical Association from the section on Obstetrics and Gynecology be appointed by the Speaker, this committee to serve until the next annual session of the California Medical Association, to elect its own chairman and secretary, and to coöperate with the American Committee on Maternal Welfare in the development of a program for the advancement of maternal welfare in California; and be it further

Resolved, That such reasonable expense be allowed this committee as shall be authorized by the Council.

Charters.—This Council recommends that charters be issued to: The Sacramento Society for Medical Improvement, the Lassen-Plumas-Modoc County Medical Society, and to the Mendocino-Lake County Medical Society.

Respectfully submitted,

The Council of the California Medical Association,

By T. Henshaw Kelly, *Chairman.*

COMPONENT COUNTY MEDICAL SOCIETIES

MONTEREY COUNTY

The regular meeting of the Monterey County Medical Society was held Friday evening, May 3, at the Hotel Del Monte. After the dinner a short business meeting was held in which SERA policies were discussed. The rest of the evening was left for the speaker of the evening, Dr. George Warren Pierce of San Francisco.

Doctor Pierce gave a very interesting and instructive talk on *Burns* and on the surgical repair following severe skin injuries. Lantern slides were used to good effect in illustration of this very fascinating subject.

WILLIAM H. LAWLER, *Secretary.*

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ORANGE COUNTY

A very lengthy meeting of the Orange County Medical Association was held at the usual time and place in the Orange County Hospital on May 7.

The new constitution was unanimously accepted and two amendments proposed, namely, the raising of the initiation fees from $2 to $10, and raising the local dues from $2 to $5.

The matter of paying city taxes was brought up, and it was felt that perhaps it was not quite just to have to pay a city tax as well as a State tax. The matter was referred to the Public Relations Committee.

Conforming to the new constitution, the election of an editor for the bulletin took place. Dr. Lawrence Cameron of Santa Ana was unanimously elected.

The first reading of the application of Dr. Thomas B. Rhone of Orange was read.

By ballot, Dr. H. Milton Counter of Buena Park was unanimously elected to membership.

Doctor Curtis reported that the Antivivisection Bill had been killed in committee.

There was some discussion on the Health Insurance Bill and considerable expression of opinion against it, as it apparently has gone through a number of changes.

Mr. Robert Speed, the manager of the newly formed Orange County Medical Bureau was present and spoke on the plans being rapidly formed and carried out for the desired functioning. This bureau is composed of the majority of the members of the Orange County Medical Association and, among other things, it will serve as a collection bureau, rating bureau, etc. Doctor Johnston of the committee read the Articles of Incorporation, and it was unanimously agreed that this corporation be formed as outlined in the Articles of Incorporation.

Llewellyn E. Wilson gave the scientific paper of the evening. His subject was *Report of the Orange County Hospital Poliomyelitis Epidemic in 1934.* Doctor Wilson is the medical resident physician of the Orange County Hospital. His talk was very interesting, and it would indicate that the 1934 epidemic was of new form or an evolution of this disease. Doctor Sutherland, the county health physician, remarked on the splendid work of Doctor Wilson and the hospital staff in this epidemic. A unanimous expression of appreciation was extended to Doctor Wilson and the hospital for his splendid work and self-sacrifice in the 1934 poliomyelitis epidemic.

WALDO S. WEHRLY, *Secretary.*

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PLACER COUNTY

A special meeting of the Placer County Medical Society was held at the Freeman Hotel, Auburn, on Saturday evening, May 4. The meeting was unique in the history of the Society in that it was not called by the secretary. The secretary, being unaware of the purpose of the meeting, was kidnapped and, by means of drugs and false promises, was taken by force to the Freeman Hotel where, upon his arrival, he found that a complimentary dinner in honor of his approaching elevation to the presidency of the California Medical Association had been prepared. There were present, on this delightful occasion, the following members and visitors:

Members—Dr. Louis E. Jones, president; Doctors C. E. Lewis, P. D. Barnes, Lucas W. Empey, Robert H. Eveleth, L. B. Barnes, J. Gordon Mackay, W. M. Miller, Max Dunievitz, W. A. Vinks, C. C. Briner, J. A. Russell, D. M. Kindopp, Ray C. Atkinson, and Robert A. Peers.

Visitors—Doctors F. F. Gundrum, A. M. Henderson, H. M. Kanner, F. P. Brendel, C. B. Jones, F. N. Scatena, Edward Babcock, Norris R. Jones, D. F. Dozier, all of Sacramento; Dr. Thomas C. O'Connor of Murphy, Dr. C. A. Wayland of San Jose, Dr. H. B. Trimble of Oakland, and Doctors E. H. Falconer and Sidney J. Shipman of San Francisco.

Dr. Max Dunievitz acted as toastmaster and master of ceremonies.

The banquet might well be described in the language of the immortal diarist, Samuel Pepys: "And after greeting them, and some time spent in talk, dinner was brought up, one dish after another, but a dish at a time, but all so good; but, above all things, the variety of wines (and excellent of their kind), I had for them, and all in so good order, that they were mightily pleased, and myself full of content at it; and indeed it was, of a dinner of about six or eight dishes, as noble as any man need to have, I think; at least, all was done in the noblest manner than ever I had any, and I have rarely seen in my life better anywhere else, even at the Court."

Between courses there were short talks by each of the members and visitors, in which many complimentary things were said regarding the guest of honor. In fact, they were so complimentary that the latter felt the speakers must have been thinking of "some other fellow."

Following the banquet the guest of honor was "booked and caned." The book was a beautifully bound copy of Dr. William Macmichael's "The Gold-Headed Cane," which was presented, on behalf of the group, by Dr. Ernest H. Falconer, who gave a short history of "The Gold-Headed Cane." Doctor Mackay then presented the secretary with a gold-headed cane, an exact replica of the one described in Doctor Macmichael's work, and carried by Radcliffe, Pitcairn, Baillie, Mead, and Askey.

At this point there was read a telegram of congratulations from Past Presidents Reinle, Hamlin and Harris, and Secretary F. C. Warnshuis, General Counsel Peart, and T. Henshaw Kelly. The tone of the telegram indicated very clearly that the boys were enjoying thoroughly their own Merritt Hospital picnic at Doctor Reinle's ranch at Calistoga, Napa County.

The meeting broke up in the early morning, with the secretary returning to his home feeling very happy.

ROBERT A. PEERS, *Secretary.*

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SACRAMENTO COUNTY

A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Orrin S. Cook, on January 15, at 8:30 p. m. The meeting was held at the Elks Temple. Sixty-three members and guests were present.

The paper for the evening, *Trends in Modern Medicine,* was delivered by Dr. Frederick C. Warnshuis, secretary-treasurer of the California Medical Association. The paper included an interesting discussion on the present status of social medicine and what is expected in its development in the immediate future.

Appreciation of the paper was voiced by Doctors Edward Babcock, Henderson, Becker, Saeltzer, C. B. Jones, Dozier, and Cook.

The secretary read the board of directors' report and introduced the new president for 1935, Dr. Orrin S. Cook.

Doctor Cook announced the committees to serve during 1935:

Publicity Committee—Doctors Dozier, O. F. Johnson, and Phillips.

Program Committee—Doctors Ankele, Becker, and Ruddy.

Banquet Committee—Doctors Norris Jones, Iki, and Schluter.

Public Relations Committee — Doctors Wallerius, Christman, Burden, Lawson, and Kanner.

Communications were read. The matter of malpractice insurance was discussed, and it was suggested

by Doctor Schoff that the matter be referred to the attorney of the California Medical Association.

Doctor Scatena reported for the Constitution Committee.

Doctor Babcock gave a short talk on the activities of the Sacramento Tuberculosis Association. It was moved and seconded that the Public Relations Committee confer with Mr. Johnson of the Tuberculosis Association. Motion passed.

Doctor Soutar gave a report on the legal requirements of physical education in the public schools and asked for closer coöperation by physicians in regard to allowing excuses from physical education classes.

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A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Orrin S. Cook, at 8:30 p. m. on February 19 in the Elks Temple. Seventy-five members and guests were present.

Mr. Harold McCurry of the Sacramento Chamber of Commerce gave a ten-minute talk, outlining the plans which the Chamber has for the future and requesting the coöperation of the medical society.

The paper of the evening was given by Dr. William Dock, associate professor of medicine at Stanford University Medical School. He gave an interesting and instructive talk on *Heart Disease Beginning in Patients Late in Life.* He spoke of the involutionary changes taking place in the arteries and muscles of the heart of an elderly person and compared them with the graying of the hair. The treatment of these diseases of the heart was outlined. The paper was illustrated by case reports and lantern slides.

The paper was discussed by Doctors O. F. Johnson, Gundrum, and Reardan.

The application of Dr. Francis J. Cox was read for the first time. The application of Dr. Loris E. Curtis was read for the second time and voted upon. Doctor Curtis was unanimously elected to membership in the Sacramento Society for Medical Improvement.

FRANK WARNE LEE, *Secretary.*

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SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubroom on May 2. The meeting was called to order at 8:15 p. m. by President C. A. Broaddus.

A supper meeting was held at the Hotel Clark at 6:15 p. m. at which there were twenty-six present, including two guests. The papers of the evening were presented by Doctors Collis, Rosasco, and D. Powell. Doctor Powell spoke on the present status of the *Social Security Insurance Bill.*

The minutes of the preceding meeting and of a meeting of the board of directors were read and approved.

The application of Dr. Martin Karr of Sonora for membership was read and referred to the Membership Committee.

Doctor Sheldon reported on the communication from the Stanislaus County Medical Society relative to the x-ray fee schedule.

Doctor Kaplan submitted the report for the Committee on the SERA.

Doctor Broaddus reported on an organization meeting of the Ethics Committee, which was held at a supper meeting at Doctor Barnes' residence, and announced that Doctor Kaplan had been appointed chairman for that committee.

Doctor McGurk announced that the family of our deceased member, Dr. L. R. Johnson, was unveiling a memorial plaque on May 26 at 2 p. m., in the Sierra, three-fourths of a mile from the Big Trees Hotel.

Doctors Karr, Rosasco, and Stewart were introduced from the floor.

The first scientific paper of the evening was given by Dr. Daniel G. Morton on *Toxemias of Pregnancy.* He spoke on the importance of the early recognition of those conditions and emphasized that the weighing of the patient, blood pressure determinations, and urine examinations should be done routinely and frequently. He also touched on their treatments. The second paper was given by Dr. J. L. Carr. His subject was *Pathologic Lesions Caused by Toxemias of Pregnancy.*

The papers were discussed by Doctors S. Sanson, P. B. Gallegos, M. Goodman, L. Collis, F. Doughty, D. G. Morton, and J. L. Carr.

President Broaddus then announced that the June meeting would be held at the new Basque Hotel.

There being no further business to come before the Society, the meeting was adjourned at 10:12 p. m. and refreshments were served.

G. H. ROHRBACHER, *Secretary.*

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SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held in the Bissell Auditorium of the Cottage Hospital on Monday evening, May 13, Vice-president Gray calling the meeting to order.

The speaker of the evening was Dr. A. C. Reed, professor of tropical medicine, University of California. He gave an extremely interesting and instructive talk on *Amebiasis,* covering the diagnosis and treatment, with particular stress on the importance of efficient public health measures. He also touched lightly on several of the other tropical diseases that would probably soon be found in California. The paper was discussed by Doctors Freidell, Roome, and Preuss.

Following this a film showing the development of *malaria* was shown.

The Society then went into executive session, and the minutes of the previous meeting were read and approved.

Doctor Steele reported for the Tuberculosis Committee, and it was moved, seconded and carried, that the secretary invite Mr. Higbee, secretary of the California Tuberculosis Association, and Miss Carlson, field worker, to come to Santa Barbara to assist in the organization of a Santa Barbara County Tuberculosis Association.

The secretary made a report on the questionnaires returned by the doctors, and it was moved by Doctor Stevens, and seconded, that a committee of five be appointed to segregate the various opinions expressed in the questionnaires and report back to the Society. An amendment to the motion was then moved, and seconded, that Doctor Stevens be a member of this committee. Carried. The original motion was put and also carried.

WILLIAM H. EATON, *Secretary.*

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SISKIYOU COUNTY

The last meeting of this Society was held at the Yreka Inn on Sunday, April 28. The committee to consult with the local SERA head was appointed, consisting of Doctors V. Hart, A. H. Newton, and Campbell.

A resolution was passed to wire State Senators McGuinness and Dan Williams and Assemblyman Fulcher that Siskiyou County Medical Society unanimously approves Senate Bill 454. Members were cautioned to pay no attention to the postals sent out by the State Chamber of Commerce.

Dr. C. C. Dickinson and Dr. Victor Hart, delegate and alternate to the State convention, were instructed to oppose the reduction of fees by the State Compensation Insurance Fund.

Doctor Newton read a paper, *A Case of Gas Bacillus Endometritis and Its Successful Treatment.* This was enjoyed by the Society and the members of the newly formed Auxiliary.

The next meeting will be held in McCloud on May 26.

LESLIE J. SEELEY, *Secretary.*

SONOMA COUNTY

The Sonoma County Medical Society held its regular meeting on May 9 at the Sonoma State Home. Forty-five members and guests were present.

Dr. F. O. Butler, medical director of the State Home and president of the County Medical Society, was host, and entertained the members and guests of the Society in his usual gracious manner.

Following a marvelous repast, the regular meeting of the Society was held in the institution's auditorium. After transacting routine business and receiving three new applications for membership, Dr. S. H. Fredrickson, anesthetist for the Home, presented a paper upon *Spinal Anesthesia,* she having administered, during the past two years, over seven hundred such anesthetics with very satisfactory results.

The meeting was well attended, the program enthusiastically received, and all went home feeling that the evening was well spent.

W. C. Shipley, *Secretary.*

TULARE COUNTY

The regular monthly meeting of the Tulare County Medical Society was held at Motley's Café in Visalia on Sunday, April 28, at 6:30 p. m. The Dental Society of Tulare-Kings County met with us as guests of the Society. Dinner preceded the meeting.

Dr. Ray Rosson presided at the meeting and welcomed our guests. The minutes of previous meetings were read and summarized with regard to the activities of the Committee on Hospitals. The Tulare County Board of Supervisors entertained the findings of the committee as submitted in the last minutes on April 16, and after a brief discussion voted three to two against the plan. Mr. Patterson and Mr. Allenbaugh were in favor of the proposed plan, and Messrs. Elliott, Armstrong, and Oliver, against it.

The pamphlet on the Health Service Insurance Act was referred to the Public Relations Committee for a report.

Doctor Rosson read an invitation from County Dairy Inspector Howard Smith to visit the laboratory at Tulare.

Dr. John S. Glenn was elected to membership in the Society, and Dr. J. Tracy Melvin's name was proposed for retired membership.

The subject of placing professional cards in the local newspapers, under a Society membership listing, was referred to the Committee on Public Relations for an opinion.

A letter from the SERA Administration was read and a committee is to be appointed to take care of this matter.

Doctor Furness proposed, and the motion was seconded and carried, that a uniform fee system be established for examination in cases of "drunk while driving": Examinations, $5; appearance in Justice Court, $5; appearance in Superior Court, $10.

Notice of this adopted schedule is to be sent to all members and to Attorney McCormick.

At the conclusion of the business session the meeting was turned over to the program for the evening. Dr. John Lloyd of Lindsay, president of the Tulare-Kings County Dental Society, responded for the dentists.

The guest speaker for the evening was then introduced by Dr. W. W. Cross of Oakland. A former Visalia practitioner, A. E. Sykes, D. D. S., of Oakland, member of the Academy of Periodontology, presented a splendid paper on *Dental Radiographic Interpretations.* Lantern slides were used in illustration. The subject dealt chiefly with calcium and phosphorus metabolism and the endocrine aspect of the findings as interpreted from x-ray studies, and opens a very important consideration in coöperative dental and medical attention to the patient. In conclusion, Doctor Cross spoke briefly on the *Endocrinologic Relationships.* General discussion and questions followed the paper, and a rising vote of appreciation was extended Doctors Sykes and Cross.

Karl F. Weiss, *Secretary.*

YOLO-COLUSA-GLENN COUNTY

The Yolo-Colusa-Glenn County Medical Society met in regular session at the Hotel Riverside in Colusa on April 24.

After the dinner the following business was transacted. A motion was made by Doctor Woolsey that a protest be made to the Industrial Accident Commission against the change in the fee schedule. This motion was carried, and Doctors Woolsey and Nichols were appointed to draw up and send such resolutions to the Industrial Accident Commission.

The SERA relief program was discussed, and Dr. Fred Fairchilds of Woodland, Doctor Walker of Willows, and Doctors Keith and Rathbun of Colusa were appointed to contact the Relief Administration officials of their respective counties and perfect a local medical relief program.

The secretary was instructed to write the State SERA, giving the names of these committee chairmen.

Dr. Edwin I. Bartlett of San Francisco gave a very interesting lecture, illustrated by slides, on *Tumors of the Breast,* giving the physiology, various types of pathology, and then giving, in a general way, the surgical treatment of these conditions.

The meeting was adjourned to meet in Willows in June.

Ray E. Nichols, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (47)

Fresno County.—Klenner F. Sharp.

Los Angeles County—

Samuel K. Bacon
Irving E. Benveniste
Lewis P. Bolander
James E. Burns
R. J. Cary
Carl F. Doehring
Nona Gilbert
W. Ray Henderson
Dorothy Hewitt
Harry H. Jacob
Carvel James
Arthur R. Jewell
Paul B. Kinney
Herman Lando
H. Ross Magee
C. W. Reeder
Joseph Rosenblatt
Hilliard E. Smallberg
Paul T. Southgate
Maxwell J. Wolff
W. W. Woods
F. B. Zombro

Orange County.—H. Milton Counter.

Riverside County.—Fred A. Clark, James B. Oliver.

San Bernardino County.—Darnell E. Hayhurst, Joseph S. Hayhurst.

San Diego County.—Howard A. Ball, J. B. Eneboe, Milo B. Fuller, Homer D. Hoskins, J. B. McConnell.

San Francisco County.—Donald G. Davy, Joel H. Hanson, Ernest William Henderson, Robert E. Hughes, Donald Eliot King, Paul D. Michelson, Isabelle H. Perry, Victor E. Putnam, James Francis Shea, Lloyd B. Shone, Harold G. Watson.

Santa Clara.—Anthony J. Monty.

Tulare County.—William A. Winn.

Yuba-Sutter County.—Philip Edward Thunen.

Transferred (5)

Marcel R. Bedri, from Monterey County to Los Angeles County.

Bertrand S. Frohman, from San Francisco County to Los Angeles County.

Jack C. Hill, from Imperial County to Riverside County.

Henry Hoagland, from Los Angeles County to Riverside County.

John A. Pearson, from Los Angeles County to Montana.

In Memoriam

Hatch, Willis Grant. Died at Santa Cruz, April 16, 1935, age 66. Graduate of Rush Medical College, Chicago, 1897. Licensed in California in 1921. Doctor Hatch was a retired member of the Santa Cruz County Medical Society, the California Medical Association, and the American Medical Association.

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Kapp, Russell William. Died at San Jose, May 5, 1935, age 36. Graduate of Hahnemann Medical College of Philadelphia, 1925, and licensed in California the same year. Doctor Kapp was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. THOMAS J. CLARK President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

REPORT OF THE PRESIDENT—FOR YEAR 1934-1935

My dear Coworkers:

It is with a feeling of sincere humility that I write my swan song as President of the Woman's Auxiliary to the California Medical Association.

A group of exceptionally loyal and untiring presidents have left records of marked achievements. The work done under their leadership has been so far-reaching and successful that this office carried with it a challenge of accomplishment.

When I assumed my duties last May I fully realized the earnest effort that must be put forth to make this year under my administration measure up to the standards of other years.

I could not have begun my work if I had not had the confident expectation of the coöperation of our entire membership—and in this I have not been disappointed. Whatever of real achievement has been ours this year is due in large measure to this cooperation.

We have grown to a point where we are no longer a group of a few workers, but an organization that stands out as an example of what enthusiasm and united effort can accomplish.

In reviewing the work of the past year, it shall be my endeavor to summarize our activities, mindful that each standing committee chairman will develop for you the work of her department and each county president will herself record the achievements of her own group. I ask for your full attention to the reports when read, as they will bring to you in clear, concise detail whatever of accomplishment has been ours. In digressing from the usual precedent of incorporating in this report of mine the activities of the various committees and counties, I have but one thought in mind—to give each one of them the full credit that is rightfully theirs, of passing on to you first hand the records of their endeavors and achievements. Furthermore, at the proper time, opportunity will be given for recommendations and your consideration of plans for future work.

In recording the highlights of the year, I am reminded of the encouragement that was mine when, in late May, a splendid group of women under the leadership of Mrs. N. N. Brown organized an Auxiliary in Kern County. I regarded this new unit as a happy augury in the beginning of the year.

Some days later I left to attend the national convention in Cleveland. The memory of that visit still lingers as perhaps the most enlightening and stimulating experience of the year. From the rather exhaustive report made after my return, you may have gathered that my reactions indicate it is not only desirable but almost imperative that an incoming state president should have the privilege of attending the national meeting which closely follows our own annual session. The contacts with national officers and other state presidents are invaluable, and at once inject the personal equation into the national perspective. In my case it vitalized my viewpoint and gave me added assurance that California was and is a necessary cog in the big national wheel.

On my return from Cleveland the good news reached me that Mrs. Sargent had effected the organization of an auxiliary in Santa Clara County. A splendid group now numbering seventy-eight members. Mrs. Sargent may well be proud of this baby of hers. We all look for great things from Santa Clara, which at this time is the sole unit representing the fifth district.

Contacts have, perhaps, been our most tangible assets. It was our good fortune to be invited and to have served as hostesses for the annual convention of the American Public Health Association in Pasadena, in September. Many members of the State Board and representative women from near-by counties gave generously of their time and effort and I may add, during unprecedented heat, to make this occasion both successful and memorable. Considerable time was given to the detailed preparation of our program during the summer. In this I was most fortunate in having as co-chairman, Miss Florence Burger of Pasadena, with whom I have been associated in civic work over a period of years. While not a member of the Auxiliary nor even remotely eligible, she possesses a medical consciousness that prompts sustained interest and activity in our field. I should like to record the appreciation of our organization for her service last fall. That the part played by the Auxiliary was a definite contribution to the American Public Health Association is best evidenced by the resolution of appreciation received from the Association some days later.

In November I made a trip to San Francisco to confer with Doctor Warnshuis, secretary of the California Medical Association. We are most fortunate to have so staunch and understanding a friend in the State official family. He was most gracious, interested in our problems, and offered his support and coöperation. You may recall that Doctor Warnshuis as Speaker of the House of Delegates of the American Medical Association presided over that group when, in 1922, Texas presented the resolution to form the National Woman's Auxiliary.

The matter of much needed additional space in CALIFORNIA AND WESTERN MEDICINE was taken up at Mrs. Belt's request by Mrs. Scatena and myself during our visit to San Francisco. Mrs. Belt made the request to Doctor Kress, who replied that this was a matter for the Council to determine. Mrs. Scatena and I then called upon Dr. T. Henshaw Kelly, chairman of the Council. He exprcssed his appreciation of the excellent work of our editor and indicated that when the matter would be presented to the Council, it would receive his approval. Subsequently, our request was granted and two full pages are allocated for our use in each issue. Space in this JOURNAL is at a premium and we are most appreciative of their generosity. Our editor now has an opportunity to present items of national and State interest as well as the reports of our county meetings. Mrs. Belt, duly authorized by the

* As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

State Board, prepared and presented in December the initial number of our State news-sheet, the *Courier*. To Mrs. Belt I give the fullest measure of praise and appreciation for this very creditable endeavor. She has brought to us and to our state organization by her own initiative and able execution a new and lasting thought of great inspirational value. Perhaps I may be pardoned at this point, a fitting tribute to her—an excerpt from a quotation recently sent me by Mrs. Chester Teass of San Luis Obispo. "A great deal of joy of life consists in doing perfectly, or at least to the best of one's ability, everything which one attempts to do. It is this conscientious completeness which turns work into art. The smallest thing well done, becomes artistic." The lines may be from William Mathews, but the thought that inspired them might well have been my own, as expressing with fidelity, the character of everything that Mary Ruth Belt undertakes.

The second edition of the *Courier* has recently appeared and gives added promise of fulfilling even to a larger degree the purpose for which it was designed. I hope that our little paper has earned for itself a permanent place in your Auxiliary heart.

At the board meeting in September, a resolution was adopted suggesting the advisability of making each county year correspond with the state year, and to that end we asked that the annual meetings of counties take place in May or June. The advantage of this procedure is obvious. It is gratifying to know that the majority of counties have responded favorably. This change will make for a better synchronization of work between county and state, and afford each county president the opportunity of making her full year's report at the annual convention.

Medicine is largely controlled by non-medical factors—harmful legislation and insidious propaganda by persons ignorant of the status and possibilities of medical science. Scientific medicine has advanced to a place of value never approached heretofore, yet it is not held in the esteem it deserves, or even that which was accorded it years ago. Thus we have the paradox of the greatest of all professions advancing in efficiency but declining in so-called popularity. It is, therefore, one of the prerogatives of every member of the Auxiliary—a definite duty—to aid in preventing and correcting adverse criticism. Through sustained public health education we can do much. We should be, as doctors' wives, the liaison between the profession and the lay public, strive at every turn to make the status of the medical man clear, to promote a better understanding of the problems that confront the profession at this time. As an example of what value we may be, let me refer to the call to arms early last autumn, when we were asked to marshal our forces in an attempt to defeat two insidious measures that were on the State ballot, initiatives number nine and seventeen. Much credit—well earned—is given the women of the Auxiliary by the California Medical Association, the Public Health League of California and many county medical units, for the outstanding service rendered which resulted in the defeat of the Naturopathic and Chiropractic measures at the fall election.

There is every reason to believe that the increase in our membership is indicative of, first, a normal, natural growth; second, a keener interest, perhaps, by some who have been sitting on the side lines waiting to see if the objectives and ideals of our organization synchronize with their own before they would join our group, and, third, the sustained activity of the membership committees throughout the State to bring into our Auxiliary those women who, through no fault of their own, were unmindful of the opportunities of service to the cause of scientific medicine which it is our devout wish to offer. One of our national past presidents is quoted as saying, "A good healthy report on organization and membership shows that a State is in a healthy condition." Perhaps this year the California climate will receive all the credit!

To Mrs. William H. Sargent I wish to express particular gratitude for her work as chairman of the committee on membership and organization. She has carried our message into many counties, and has the promise of additional organized units this coming year. I believe her efforts are of inestimable value. She has the Auxiliary in her blood stream and is equipped with unusual ability to "sell" the Auxiliary idea. It is heartening to consider the unselfishness of Mrs. Sargent in her willingness to continue her invaluable service on the board after years in executive positions. I salute her fine spirit and her achievements, and am grateful.

Our Public Relations Committee has presented an outstanding program this year, and has been entirely successful in the consummation of plans for increased activity in every county. The field is a large one and an open one. The very nature of the work demands as a leader, a woman of vision, initiative and ability, who recognizes the resources of a few and the limitations of many county units, and who will not demand or expect the impossible from any. Mrs. Barrow has carried on in a superlative manner, injecting into her work the enthusiasm and optimism for which she is known to be richly endowed. I believe that this year will show better results because of the coöperation she has had from the county public relations chairmen, which is a necessary factor in the correlation of a program of such vast possibilities. Mrs. Barrow has laid the foundation for great work in this field and has intelligently interpreted the need of our sustained interest in an active contact with other organized groups. In thanking Mrs. Barrow for her endeavors I am only voicing the appreciation of every member of the Auxiliary.

There is noticeable a splendid spirit of coöperation and an increased interest in health education matters, as is evidenced by the added number of requests that have come to us for information as to the subject matter for health programs in the schools, women's and civic organizations. I am happy to say that a "Health Institute" is to be incorporated in the fall program of one of our southern counties, San Diego, and another in the north, Alameda. The idea, sponsored by Philadelphia, should prove of great value, and it is my hope that it will find a definite and permanent place on the annual calendar of many counties in the near future. I thank Mrs. Howard for her part in this work.

Mrs. Sutherland has inspired greater efforts in all matters concerned with public health activities and has by her contacts strengthened our position, and stressed the need for closer relationship with those organizations which share with us a common interest.

We are deeply indebted to Mrs. Baxter and the members of her committee for increased interest in *Hygeia*. Their reports are most gratifying, showing that California's quota has been exceeded this year. However, we do not feel that the official health magazine of the American Medical Association has received the recognition it deserves. How best to stimulate interest and increase subscriptions still remains a problem. With a membership as large as ours, surely it is not too much to expect an average of one subscription to each member, or perhaps ask each member to be responsible for one subscription. The members of the *Hygeia* Committee have worked diligently and intelligently and are deserving of immeasurable praise for their sincere efforts.

We have been particularly fortunate in our recording secretary, Mrs. Henderson. Her work has been carried on with meticulous care, and into every detail she has fused a charm that has come to her through the gentleness of her personality and the understanding of doing her work well.

Correspondence of the year has, perhaps, made the greatest demands on many of us. A large portion has fallen to the lot of Mrs. Spiers, who has carried on with a smile and with her usual efficiency. I knew full well when she accepted my one and only appointment last May, that she would contribute much comfort to me personally, and leave a creditable record of service to the State organization. I can assure you that both contracts have been graciously carried out.

Our finances have been in the safekeeping of our esteemed treasurer, Mrs. Scatena, for the second year. With increased membership, her work has increased, and by the same token, we trust our balance may have taken on added weight. Mrs. Scatena's report will give you the story in her own word figures. I cannot emphasize enough the importance of her responsibilities or the value of her contribution to the Auxiliary, which we all acknowledge with affectionate appreciation.

Our historian this year, Mrs. Coulter, will present her story in a new garb. Until recently we have had a combination scrapbook and history. Frankly, in our opinion, these two records are deserving of separate settings. The history belongs to the historian and should be preserved with dignity and fidelity; the scrapbook belongs under the jurisdiction of the chairman of publicity, and should give evidence of the contribution of the press, both newspaper and magazine, of State Auxiliary activities, notices of meetings, convention data and other items of interest as the name of the book would imply. The scrapbook is at the moment in a state of transition, but when it appears next year at the convention, you may look for something creditable, the result of Mrs. Belt's labor of love.

Our State Board meetings have been well attended and at no time have we lacked a full quorum. Many county presidents have attended and expressed their pleasure in being included, and of having an opportunity to discuss county problems. An interchange of ideas is often valuable and still more often, quite desirable, and of mutual interest. My confrères on the State Board have carried the major portion of the burden of the work this year. Each officer has responded in a most gratifying manner to any request of mine for advice or assistance. My task has been a pleasant one, made so by the graciousness and kindness of my associates.

Six years have passed since the Auxiliary was organized. To me it seemed fitting that some recognition should be made of the work of those members who have contributed to our upbuilding, and who are no longer with us. Mrs. Percy in her "In Memoriam" today has inaugurated a memorial service which I believe should find a permanent place each year on our program.

The early spring of this year brought me a truly great moment, when a telegram came announcing the reorganization of San Luis Obispo Auxiliary. We all rejoice and welcome this splendid group back to the fold after a period of rest. For me, this action of theirs is a crowning tribute to the loyalty of old friends who have served well, and who by their renewed activity will reflect the importance of united effort in our organization.

Through the coöperation of the presidents of our southern counties, we have been able to respond to the request of the officers of the Southern California Medical Association for assistance at their recent session at Arrowhead Springs. The women from San Bernardino, close at hand, were called upon to assist in the various activities offered on the program. It is my pleasure to report that through Mrs. Arthur Walker and Doctor Roblee, a reorganization of the Auxiliary in San Bernardino is assured.

I wish to extend to Dr. William W. Roblee, chairman of our Advisory Council, my sincere appreciation for his coöperation at all times. He has been most generous in the time he has given me for conferences, has assisted our cause by making addresses to stimulate activity in unorganized counties, and in every way has contributed of his time and thought in the interests of the Auxiliary.

We are indebted to Dr. George H. Kress, editor of California and Western Medicine, for many courtesies.

I wish to refer with deep appreciation to the hospitality that has been accorded me during the year by many county groups. I have enjoyed these meetings and am grateful for the joyous contacts on each and every occasion. Were it not for the physical limitations, I would have been able to visit every county, and deeply regret my inability to accept the courtesies extended to me by Santa Barbara, San Luis Obispo and Sacramento to meet with their groups in March and April.

I cannot bring this summary to a close without expressing a word of appreciation to our national president, Mrs. Tomlinson. While the distance of the entire continent separates us, she has been good enough to make us feel a real sense of nearness in her letters, and in her sustained interest and concern in all matters affecting California.

To Mrs. Clarke, who will so soon follow me, I bequeath the fulness of joy that has been mine in serving you, and added assurances of our loyalty and coöperation. May she, too, find a great content in the benediction of abiding friendships.

To you, each one, I say "Thank you."

Helen Stewart Doane.

* * *

In Memoriam

By Mrs. James Fulton Percy

On this, the occasion of the sixth annual meeting of the California State Auxiliary, it is appropriate that we should take notice of the workers among our members who have passed on and who, in the previous years, have added so much to the stability and purposes of this organization.

Our president, Mrs. Doane, in inaugurating this memorial service, has, with especial insight, consummated the unexpressed wish in our hearts that those of us who are still permitted to carry on, might pause for a moment and recall the worth and works of the departed for the general upbuilding of the Auxiliary.

Our first thought is that they were doctors' wives and, therefore, had learned to share with their husbands the sympathy, understanding and wider vision that is the progressive endeavor of every physician in his humanitarian work. In the memory of great, human, loving kindness, there exists the seed of an imperishable joy which proves itself a sufficient foundation for man's faith.

Life has a strange and mysterious way of deciding for us when the day's work is done, and records such as are left by these friends and members are an inspiration to those who come after to do their share for the common weal. The Prophet has said, "The days of human existence are as vanishing shadows." "Our life is scarce the twinkle of a star, in God's eternal day."

The foundations of life are still far beyond the reach of investigation but among its realities as we perceive it, is the sense of trust in continual goodness and abiding love.

In the majestic grandeur of this wonderful valley, with the mighty sequoias that have flourished while countless civilizations have come and gone, the aisles of the sounding pines, its silences and shadows and the whisperings of peace, its suggestion of every kind of abundance, replica of life itself, we dedicate this service of loving remembrance, not only to our own dear members gone but as well to those faithful husbands who also, though lost to sight, to memory are ever dear. So unto our beloved dead, who are not dead, belong the homages of song, for from their lives we draw anew our dream of immortality.

As we bow our heads during the reading of the names of these friends, who during the past year have answered the final summons, there must come to us, deep in our hearts, promptings to fresh endeavor, to renewal of inspiration to carry us on to wider prospects, that continued hope may come with the south wind and courage with the sunrise.

Alameda County—Mrs. O. D. Hamlin and Miss Anna D. Kohlmoos.
Contra Costa County—Mrs. C. L. Abbott.
Los Angeles County—Mrs. John R. Haynes.
Orange County—Mrs. H. W. Robertson.
Riverside County—Mrs. Arthur W. Miller.
Sacramento County—Mrs. Burt F. Howard.
San Diego County—Mrs. W. S. McCauslane.

NEVADA STATE MEDICAL ASSOCIATION

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COMPONENT COUNTY MEDICAL SOCIETIES

WASHOE COUNTY

The regular monthly meeting of the Washoe County Medical Society was held on the evening of May 14 in the State Building, Reno, Dr. M. A. Robinson presiding.

There was very little business to bring before the Society, except a resolution by Mrs. Alexander of Washington, D. C., who is on the national committee for federal legislation for birth control. Mrs. Alexander read a copy of the resolution with reference to birth control, such as was adopted by the national committee, and asked the Society to endorse it and send such endorsement to headquarters. The resolution was discussed pro and con, and the secretary was directed to correspond with the legal department of the American Medical Association to ascertain their opinion with reference to the same and report at the next regular meeting of the Society.

A resolution was read by the secretary, in substance directing the attention of the Society to the advisability of participating by prize donations or of helps to the students of the University of Nevada, especially those in the pre-medical department. The importance of the action suggested that the resolution be continued until the next meeting for final action.

There being no further business, the paper for the evening by Dr. John A. Fuller was called for. The subject of Doctor Fuller's paper was *Suppuration of the Middle Ear.* In substance, he said about as follows:

Probably no pathological condition causes more suffering and economic disaster than suppuration of the middle ear. It is estimated there are one million persons in the United States who are direct or remote sufferers from this affliction. The importance of this disease is that the general practitioner is the one who sees it first, and in many instances the treatment is of such temporary nature that before seen by a specialist damage to the middle ear and its structures is well under way. . . . It is readily seen that inflammation of this canal leads to swelling and occlusion of the tube, with the result that the tympanum becomes a walled-off cavity. This is exactly what happens in most cases of middle-ear infections. Pus sooner or later forms, and in expanding it follows the line of least resistance, with the result that the ear drum is ruptured. But in some instances the pus backs up through the additus, to the mastoid antrum, and then the patient has mastoiditis. It is true that not all cases go on to suppuration because, drainage being restored, pressure is removed and recovery follows.

A large majority of middle-ear infections originate in the nasopharynx; therefore the nose and throat should be inspected as being the principal etiologic factor. . . .

Symptoms were described, first, as a feeling of uneasiness, followed by lancinating pain. Fever and leukocytosis appear. Examination of the ear drum is imperative. This should be followed promptly by early drainage, if not by incision; then by such method or means as will cause shrinking of the nasal mucosa, thereby opening up the tubal orifice and restoring drainage.

The patient should be put to bed. The room should be warm and the usual treatment for any acute illness should be initiated. If seen early, in addition to the foregoing treatment, packing the entire external canal from the meatus to the drum lightly but firmly with plain cotton. This procedure immobilizes the drum head and equalizes the pressure from within, and usually relieves the pain almost instantly. If not quickly relieved, hot moist compresses to the side of the head and lower part of the neck hasten dilation of the blood vessels and assists absorption. Doctor Fuller expressed his opinion positively as against the usual treatment by the use of ear drops, as such clog up the external canal and obstruct visualization of the drum. If after a few hours these measures are not successful, or should the drum show distinct bulging, then a paracentesis under general anesthesia is done, and this is followed by hot compresses. Infected tonsils and adenoids should be removed if the suppuration tends to become chronic.

When treated by empiric measures the tendency is for the patient to develop a chronic otitis media. This is one of the most distressing of all human maladies. The suffering is not only physical, but mental. The patient with this affliction is in the million class. The small child in school is considered dull because he is not able to comprehend what is said to him, and as he grows into adult life, deafness, which has a tendency to increase in intensity as the patient becomes older, frequently bars the individual from many of the avocations of life. The earnest intent of the physician should be when he encounters a case of otitis media to immediately call in competent surgical help to forestall a condition which, if allowed to continue, may cause death through its many possible complications, or at best leave the individual crippled for life by defective hearing. THOMAS W. BATH, *Secretary.*

Essay on Recovery of Medical Prosperity.—The *Japanese Medical Journal* offered a prize for an essay on "How to Tide Over the Present Difficult Situation in the Medical Profession." In a six months' period eighty-three essays were received, most of them written by practitioners. The winners were recently made known. Dr. K. Nakadate won the first prize, 500 yen. In his essay he said that the causes of the present difficulties are, first, the surplus of physicians, which must be corrected by changing the system of medical education so as to divide the specialists and the general practitioners. The last two years in the medical college should be devoted to specialized education and the previous years to general education. A certificate for practice should be given after two years' practical training in approved hospitals after the student has finished the college courses. In the second place, any treatment done by those who are not physicians but are now sanctioned by the local governments should be entirely prohibited except when the practitioner recommends that they treat a patient under his personal guidance. Third, any health benefit associations organized under the pretext of lower medical fees should be dissolved, as they tend to commercialize the profession and prevent patients from exercising a free choice of physician. Fourth, the indiscriminate manufacturing of new medicines should be ended by careful regulation. The doctor with little experience is more apt to administer expensive new medicines and this is one reason for the high cost of medical care. The selling of medicine by practitioners has caused many complaints, and the lower classes are inclined to refrain from consulting the doctor lest they be obliged to pay too much. This is an essential cause of the present trouble, to say nothing of the general business depression. Fifth, medical advertisements, especially on the roadsides or in the stations or on roofs, should be utterly prohibited. They destroy dignity and induce the people to despise medicine. Supplementary education to promote the practitioner's knowledge should be published by the medical association in a periodical with the latest scientific research and clinical experiences of physicians. Concluding, he says that there should soon be established the most rational medical system. The tendency of regarding medical practice as a commercial product he despises. He holds that medicine is a benevolent art and should be practiced in this principle.—Japan News Letter.

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Association for the Study of Goiter, Salt Lake City, June 24-26, W. Blair Mosser, M. D., 133 Biddle Street, Kane, Pennsylvania, Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

Nevada State Medical Association, Elko, Nevada, October 25-26, 1935. Horace J. Brown, P. O. Box 698, Reno, Secretary.

Pacific Northwest Medical Association, Spokane, Washington, June 27-29. C. W. Countryman, M. D., 407 Riverside, Avenue, Spokane, Washington, Secretary.

Medical Broadcasts*

American Medical Association Health Talks.— The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, Chicago daylight saving time (3:30 p. m. central standard time).

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, Chicago daylight saving time (3 p. m. central standard time).

* * *

San Francisco County Medical Society.— The radio broadcast program for the San Francisco County Medical Society for the month of June is as follows:

Tuesday, June 4—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 11—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 18—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 25—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.

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Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of June is as follows:

Saturday, June 1—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 1—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 4—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 8—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 8—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 11—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 15—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 15—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 18—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 22—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 22—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 25—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 28—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 28—KFAC, 10:15 a. m. Subject: Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Stanley P. Black Memorial Lectures.—The 1935 lecture of this series was held in the Stanley P. Black Memorial Hall, 65 North Madison Avenue, Pasadena, on Wednesday, May 1, at 8:15 p. m.

The guest speaker was G. V. Anrep, M. D., F. C. D., F. R. S., professor of physiology, medical faculty of the Egyptian University, Cairo, Egypt, who spoke on the subject, "The Regulation of the Coronary Blood Flow."

Leslie Dana Gold Medal.—The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, will be presented this year to Dr. William H. Wilder of Chicago, it is announced by Lewis H. Carris, managing director of the National Society for the Prevention of Blindness. Doctor Wilder was selected for this honor by the National Society in coöperation with the St. Louis Society for the Blind.

The medal, offered annually by a director of the St. Louis Society, is a prized mark of recognition of service for the conservation of vision. It will be presented to Doctor Wilder at ceremonies in St. Louis on May 18. The medal bears the inscription: "Wise Clinician, Devoted Teacher and Humanitarian."

Doctor Wilder is secretary-treasurer of the American Board of Ophthalmology; vice-president of the Illinois Society for the Prevention of Blindness; professor emeritus of ophthalmology at Rush Medical College, University of Chicago; and a past president of the American Academy of Ophthalmology and Otolaryngology.

The Leslie Dana Medal was awarded last year to Professor F. de Lapersonne of Paris, president of the International Association for Prevention of Blindness.

American Association for the Study of Goiter.—The tentative program for the 1935 meeting, to be held on June 24, 25, and 26, at Salt Lake City, Utah, includes papers as follows:

Etiology and Treatment of Recurrent Hyperthyroidism—Dr. Gordon S. Fahrni, Winnipeg, Canada.

Malignant Goiter—Statistical Survey of Sixty Cases, with Comparison of Geographical Types—Dr. Robertson Ward, San Francisco.

Some Problems in Thyroid Disease—Dr. Frank E. Rogers, Denver, Colorado.

Calcinosis Universalis—Dr. Edwin G. Ramsdell, White Plains, New York.

The Etiology of Hyperparathyroidism — Collaboration with Dr. L. P. Howell of the Clinic—Dr. Russell M. Wilder, Rochester, Minnesota.

Myxedema and Hypothyroidism—Dr. S. D. Conklin, Sayre, Pennsylvania.

Thyroidectomy for Psychosis of Hyperthyroidism—Dr. LeRoy Downing Long, Oklahoma City, Oklahoma.

Twenty Years' Experience in the Management of Goiter —Dr. E. C. Moore, Los Angeles.

Toxic Adenoma of the Thyroid with Associated Hypothyroidism—Dr. H. H. Searls, San Francisco.

Malignant Exophthalmus—Dr. George W. Swift, Seattle, Washington.

The Surgery of the Parathyroid Glands—Dr. Fred W. Rankin, Lexington, Kentucky.

Riedel's Struma—Dr. Frederick A. Coller, Ann Arbor, Michigan.

The Lingual Thyroid—Dr. M. L. Montgomery, San Francisco.

Quantitative Observations on the Effect of Iodin in Exophthalmic Goiter in Chicago—Dr. Willard O. Thompson, Chicago, Illinois.

A Clinical Analysis Plus Unusual Cases—Dr. Millard Rosenblatt, Portland, Oregon.

Tendency Toward the Medical Treatment of Exophthalmic Goiter—Dr. Arnold Minnig, Denver, Colorado.

Licensing in California of Foreign Graduates in Medicine.—From a letter we quote: "California Senate Bill 155 amends Section 10 of the Medical Practice Act, requiring graduates of foreign schools to serve a one-year internship in a hospital in the United States or take a senior year in an approved medical college in the United States. The measure passed the Senate and is on third reading file in the Assembly. It should be passed because of the fast developing influx of foreign medical graduates, whose credentials are practically impossible to satisfactorily verify, particularly Russian and German."

American Urological Association Meeting. — The coming meeting of the American Urological Association, which will be held in the Palace Hotel in San Francisco on June 26 to 28, will be attended by many of the prominent urologists of the United States, a number of eminent foreign guests, and practically every physician interested in urology in the western portion of the United States.

Dr. Luigi Caporale of Torino, Italy, will participate. He has been specially delegated to attend by Mussolini, who realizes the great importance of international contact and interchange of medical ideas. Dr. Aquilino Villanueva, Secretary General of the Department of Public Health of Mexico City and chief urologist of the Hospital General, and one of the outstanding urologists of our sister republic, will also attend. A number of prominent American urologists will converge toward San Francisco in June. Lowler and his associates will come from Cleveland, Ohio, and present interesting papers on the control of prostatic hypertrophy by the use of hormones which they have discovered and which promise to be an additional method of attack for the relief of prostatism. Russell S. Ferguson of New York will talk on the control of cancer of the genito-urinary tract. Bud Corbus of Chicago will talk on the Corbus-Ferry gonococcus filtrate which has proven to be a great adjunct in the treatment of gonorrhea. Tuberculosis of the genito-urinary tract will be discussed by T. Leon Howard of Denver, who has had wide experience in the treatment of urinary tuberculosis. David W. MacKenzie of Montreal, Canada, will relate the results obtained in making an experimental study of the relation of infections of the genital and lower urinary tract to those of the kidney. E. Granville Crabtree of Boston will present new ideas concerning the roentgenological diagnosis of urological and gynecological disease of the female bladder. An interesting paper will be that of Richard Chute, also of Boston, who will show the relationship between hyperthyroidism and the formation of kidney stones. Other urologists who will attend and who have assisted in making American urology are: Nathaniel P. Rathbun of Brooklyn, past president of the American Urological Association, Henry G. Bugbee of New York, C. R. O'Crowley of Newark, and Oswald Lowsley, a former Californian, and now director of the Brady Urological Institute of New York.

Professor Hugh Hampton Young, director of the Brady Urological Institute of Johns Hopkins University, will deliver the Ramón Guiterras lecture. Professor Young is the first American urologist who has been selected to deliver this lecture which heretofore has been given by eminent foreign urologists. He has selected for his topic: "The Abnormalities and Plastic Surgery of the Lower Genito-Urinary Tract."

It is well that the medical men of the West interested in urology should plan their vacations in order to attend the coming meeting of the American Urological Association to be held in San Francisco this summer. It will afford an opportunity to hear the most prominent urologists of the Western Hemisphere and to become acquainted with the latest developments and newest discoveries in the urological field. Information concerning the meeting may be obtained from Charles P. Mathé, M. D., Chairman, Publicity Committee, 450 Sutter Street, San Francisco.

California Cities Win Health Contest.—For the last six years the Chamber of Commerce of the United States, in coöperation with the American Public Health Association, has been conducting a nation-wide public health contest for cities of different sized populations. The winners for 1934 have just been selected.

The contest, open to cities anywhere in the country, is for the purpose of determining which cities of various populations are carrying on the most effective community public health programs, in an effort to prevent unnecessary and premature deaths and economic losses due to preventable illness.

In the larger cities, of 500,000 population and over, the first award goes to Baltimore, Maryland, and honorable mention to Buffalo, New York.

In Group II, cities of 250,000 to 500,000 population, Newark, N. J., attains the first award, and honorable mention goes to Minneapolis, Minn.; Toledo, Ohio; and Dallas, Texas.

In Group III, cities of 100,000 to 250,000 population, Honolulu, Hawaii, wins first place, and honorable mention goes to Hartford, Conn.; Grand Rapids, Mich.; Springfield, Mass.; Duluth, Minn.; Yonkers, N. Y.; Reading, Pa., and Utica, N. Y.

Group IV, cities of 50,000 to 100,000 population, *Pasadena,* receives the first award, and honorable mention goes to Kalamazoo, Mich.; Schenectady, N. Y.; Evanston, Ill.; Waterbury, Conn.; *Sacramento*; Binghamton, N. Y.; *San Jose*; New Rochelle, N. Y., and Greensboro, N. C.

Group V, cities of 20,000 to 50,000 population, the winner is Hackensack, N. J., and honorable mention goes to Watertown, N. Y.; Pittsfield, Mass.; Auburn, N. Y.; Greenwich, Conn., and *Santa Barbara.*

In Group VI, cities with a population under 20,000, *Palo Alto,* obtains the first prize, and honorable mention goes to Englewood, N. J.; Cliffside Park, N. J.; Hibbing, Minn., and Miami Beach, Fla.

Special awards to a small group of cities which were excluded from the contest proper for having twice won first place in their respective population groups and at the same time maintaining their high standards of health achievements in 1934, were granted to (arranged alphabetically) Brookline, Mass.; Detroit, Mich.; Milwaukee, Wis.; New Haven, Conn., and Syracuse, N. Y.

With 214 cities entered, representing forty-four states, the Islands of Hawaii, and Alaska, there were forty awards given. These awards, including both winning and honorable mention prizes of the contest itself and the special awards to cities which have twice previously won the contest, were distributed over fifteen states. New York State led the country with nine awards, followed by California with five. Four prizes each went to Connecticut and New Jersey; and Massachusetts, Michigan, and Minnesota received three each. One award each was given to Florida, Hawaii, Illinois, Maryland, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin.

Of the first-place winners, California received two; New Jersey two; the Islands of Hawaii one, and Maryland one. The fact that New York and California won so many awards is probably due not only to the fact that they both have splendid examples of good local health services, but also to the very active support and help of the State Department of Health in these states.

Cities are graded on such items as the safety and availability of water supplies, sewage disposal, supervision and protection of milk supply, the extent to which children are protected against communicable diseases as diphtheria and smallpox, how many expectant mothers are obtaining proper prenatal care, how many babies are being kept well by adequate medical supervision, and to what extent are physicians and dentists in private practice carrying on preventive medical and health promotion services.

It is very gratifying to find that the death rates are declining more rapidly in the cities participating in the contest than in the country as a whole. This may well reflect the greater progress made in all health matters in these cities.

Accidental Deaths in California.—The California State Department of Public Health has released the statistics on accidental deaths in California for the year 1934, showing as follows: Total occupational deaths, 414; public deaths (not motor vehicle), 1,025; accidental deaths in the home, 1,292; accidental deaths charged to motor vehicles, 2,798; type unknown, 37.

American Public Health Association.—Dr. Eugene L. Bishop, president of the American Public Health Association, announces the appointment of Reginald M. Atwater, M. D. Dr. P. H., as executive secretary of the association.

The American Public Health Association is the technical society of the professional public health workers of North America. Its sixty-fourth annual meeting will be held in Milwaukee, October 7 to 10.

Anesthesia Control Subject of Meeting.—Ways and means of controlling the use of divinyl oxid as a general anesthetic in order to prevent its use by unauthorized or incompetent persons, were discussed at a recent meeting at the University of California Medical School, attended by Dr. Randolph T. Major, New York City; Dr. A. E. Guedel, Los Angeles; Dr. Dorothy Wood, University of California Hospital; and Dr. C. D. Leake, professor of pharmacology of the University of California Medical School.

The agent of divinyl oxid was developed at the Medical School and recently has come into wide use, both in the United States and abroad. It is one of the most powerful anesthetics known and, if properly used, induces quicker recovery and less discomfort than other agents. It was given its first surgical use at the University of California Hospital, with Doctor Wood as anesthetist, when, according to Doctor Leake, "its practical advantages were clearly evident."

Babies Are Safe in San Francisco.—The Department of Public Health of the City and County of San Francisco on May 13 issued a bulletin as follows:

The following are comparative health statistics for thirteen major cities in the United States. Particular attention is called to the remarkable record in San Francisco as to the infant death rate, which justifies the slogan consistently used by this Department of Health, namely, "Babies are safe in San Francisco."

Attention is also called to the irreducible minimum rate with reference to diphtheria. Needless to say, I am very proud of this showing.

J. C. Geiger, M. D., *Director.*

*Comparative Health Statistics**
(Cities of over 500,000 Population)

City	Death Rate	Infant Death Rate	Tuberculosis (All forms) Death Rate	Diphtheria Death Rate
San Francisco..	11.65	33.0	66.0	0.15
Los Angeles.....	11.71	52.71	81.45	3.2
New York.....	10.15	52.22	59.14	1.38
Chicago	10.4	47.7	55.6	1.2
Philadelphia	12.47	53.78	70.32	1.09
Detroit	8.8	50.7	61.9	0.7
Cleveland	10.7	44.8	69.1	3.0
St. Louis	13.99	58.0	59.95	4.51
Baltimore	13.3	65.3	77.9	0.8
Boston	14.24	54.88	66.0	1.1
Pittsburgh	11.9	54.9	51.6	5.4
Milwaukee	8.1	44.0	30.0	1.5
Buffalo	11.6	56.3	60.1	1.0

* The above tabulation is copied from the annual report for the City of Milwaukee, for 1934.

The American Association of the History of Medicine.—The eleventh annual meeting of the American Association of the History of Medicine was held in Atlantic City, New Jersey, on May 6, 1935. The program was dedicated to the memory of Dr. Joseph P. O'Dwyer, who was one of the world's greatest medical benefactors to sick children. Fifty years ago he demonstrated to a skeptical medical profession his improved laryngeal tubes and published his first article on this new and, as it proved, life-saving method for treating severe forms of laryngeal diphtheria.

Through the courtesy of Professor James W. Crane of the University of Western Ontario at London, Ontario, and Professor Jabez H. Elliott of Toronto, Ontario, there was exhibited both the bag in which Doctor O'Dwyer carried his intubation set and a complete assortment of models of the tubes by which he saved, and taught other physicians to save the lives of hundreds of children, many of which would, without the aid of the intubation tube, have died a wretched death of slow strangulation.

It was eminently fitting that the address concerning Doctor O'Dwyer and his work should have been made by Professor Chevalier Jackson who, following Doctor O'Dwyer originated and popularized in the medical profession another life saving and health promoting method of direct visual diagnosis and equally direct treatment, namely, bronchoscopy and esophagoscopy. Dr. William S. Middleton of Madison, Wisconsin, was elected president and Dr. Walter C. Alvarez of Rochester, Minnesota, vice-president. For additional information write to the secretary, Dr. E. J. G. Beardsley, 1919 Spruce Street, Philadelphia.

Tropical Disease (Onchocercosis) Moves Northward.—A much-feared tropical disease, widely disseminated throughout portions of Africa, has now been encountered in the highlands of Guatemala and southern Mexico. A definite northward trend of this disease has compelled far-reaching defense measures to prevent it from invading the United States. The disease is known as onchocerosis, a parasitic malady which, in its advanced stage, may cause blindness and other serious complications. Although there are no known cases in California, the buffalo gnat and related simuliid insects of the high Sierra and other elevations in the State, are known to be potential carriers of the disease.

The stricken black slaves from the African forests, with their nodule-covered heads and bodies, probably introduced this tenacious African disease into the New World. While the disease is not necessarily fatal and may be cured or checked by surgery in the lighter cases, it can cause blindness, delirium, convulsions and other complaints. The problem of control is greatly aggravated by the fact that the insect carriers hatch in swiftly running streams at high altitudes.

The Hooper Foundation for Medical Research of the University of California and the Pacific Institute of Tropical Medicine, within the Foundation, are closely watching the creeping northward course of this disease, and it is being as closely observed by other medical centers throughout the United States. The movement of Mexicans across the border, particularly those from the states of Chiapas, Oaxaca and Guerrero where the disease is now established, is being given particular attention.

A recent bulletin on onchocercosis, prepared by Dr. Herbert G. Johnstone and Dr. Albert E. Larsen of the Pacific Institute of Tropical Medicine in the University of California, details the history of this disease in North America and draws the following conclusion:

"The numerous Mexican immigrants in the United States provide an opportunity for the presence of a carrier of onchocerca caecutiens. This may lead subsequently to the contamination of our own simuliid species. If this occurs, a case of the disease is sure to make its appearance sooner or later, and once present it is difficult to eradicate."

Exhibit of Rare Medical Books at the University of California Medical School Library.—The University of California Medical School Library announces an exhibition of rare books recently presented to the Medical School by Mrs. Myrtle Crummer Ingram, in memory of her late husband, Dr. LeRoy Crummer. Among the books shown are the 1651 edition of Harvey's work on generation; a Latin edition of the great Renaissance work on obstetrics, "Rösslin's "de Partu Hominis"; Phrysius' "Spiegl der Artzny"; the 1628 edition of Aselli's "De Lactibus," and the famous poem by Alexander Pope, "An Epistle to Dr. Arbuthnot."

Bovine Tuberculosis.—Kansas, on May 1, was officially recognized by the United States Department of Agriculture as the nineteenth state practically free of bovine tuberculosis. The state was thus established as a modified accredited area, where tuberculosis among cattle has been reduced to less than one-half of one per cent. The other states are North Carolina, Maine, Michigan, Indiana, Wisconsin, Ohio, Idaho, North Dakota, Nevada, New Hampshire, Utah, Kentucky, West Virginia, Washington, Illinois, Oregon, Virginia, and Minnesota.

The testing of cattle for tuberculosis has been speeded up in Kansas during recent months through the use of emergency funds provided by the Jones-Connally Act.

The campaign to eradicate bovine tuberculosis is progressing rapidly in other states and during March 2,690,074 cattle in approximately 250,000 herds were tested—more than in any previous month in the history of the work.

American College of Surgeons — Clinical Congress and Annual Session at San Francisco. — For the twenty-fifth annual clinical congress, Monday, October 28 to Friday, November 1, the surgeons of San Francisco and Oakland have organized under the leadership of a representative committee, with Dr. Howard C. Naffziger as chairman, and are preparing a clinical program that will adequately present the surgical activities of that great Pacific Coast medical center.

The congress will open Monday morning at ten o'clock, with the annual hospital conference at the Fairmont Hotel. Clinics at the hospitals are scheduled for Monday afternoon at two o'clock, and will be continued during the following four days both morning and afternoon. A comprehensive and varied program of operative clinics and demonstrations, representing all departments of surgery, is being prepared. This will include a special series of clinics in surgery of the eye, ear, nose, and throat. The committee is also preparing programs for four morning sessions, at which distinguished ophthalmologists and otolaryngologists will present and discuss subjects of clinical interest.

Programs are being arranged for five evening meetings, at which eminent surgeons of the United States and Canada and a number of distinguished visitors from abroad will present and discuss papers dealing with surgical subjects of present-day importance. Plans are being made also for conferences on cancer, fractures, and industrial medicine and traumatic surgery. The president-elect, Dr. Donald C. Balfour, of Rochester, Minnesota, will be inaugurated at the presidential meeting on Monday evening. At the annual convocation of the College on Friday evening, when the 1935 class of candidates for Fellowship will be received, the Fellowship address will be given by Dr. Robert Gordon Sproul, president of the University of California.

Headquarters will be established at the Fairmont and Mark Hopkins hotels, the registration and information bureau, scientific and technical exhibitions, executive offices, etc., being located at the former. Ample first-class accommodations are available at nearby hotels. The railroads have authorized low round-trip rates from all sections of the country.

Attendance will be limited to a number that can be readily accommodated at the clinics so that registration in advance is necessary.

"Differences of Opinion as to Policies."—A recent bulletin of the Committee on Economics of the Medical Society of the State of New York prints: With this brief explanation the Milbank Memorial Fund announced the termination of the services of John A. Kingsbury and others, and, likewise, clearly indicated a new understanding of the individual medical practitioner's social and economic problems.

This event marks a new trend in the application of philanthropic funds to the present day and future needs of the professions and the people. Guidance by medical opinion, founded upon practical experience in the economics of the provision of medical care to all classes and conditions of people, will bring greater and more beneficent accomplishments than have been attained in the past.

Medicine is deeply indebted to Mr. Louis J. Auerbacher, president of the Dryco Company and director of medical relations of the Borden Company. His recognition of an opportunity to serve the common interests of all, his intelligent understanding and cordial, effective coöperation has changed the direction of one powerful current of influence.

American Proctologic Society. — The 1935 meeting will be held at Atlantic City on Monday and Tuesday, June 10 and 11, with headquarters at the Marlborough-Blenheim.

The American Proctologic Society, organized in 1899 for the purpose of "investigating and disseminating knowledge relating to the rectum, anus, and colon," is a society with a definitely limited membership, divided into fellows, associates, honorary fellows, and honorary associates.

Regular and orthodox practitioners, members of the American Medical Association, and not affiliated with medical groups admitting those not members of the American Medical Association, are cordially invited to attend the thirty-sixth annual meeting in Atlantic City, Monday and Tuesday, June 10 and 11—the week of the American Medical Association meeting.

Physicians fulfilling the above requirements who are especially interested in proctology are eligible to submit applications for associate membership after attending at least one meeting of the society and one meeting of the American Medical Association Section.

For additional information, address the secretary, Frank G. Runyeon, M. D., 1361 Perkiomen Avenue, Reading, Pennsylvania.

Medical Library Association. — This organization, founded in 1898 and incorporated in 1934, has its headquarters at 25 Shattuck Street, Boston, Massachusetts. Its thirty-seventh annual meeting of the Medical Library Association will be held in Rochester, New York, June 17 to 19. Sessions will be held at the Rochester Academy of Medicine and the University of Rochester Medical School.

The program includes addresses, round-table discussions and demonstrations on library procedure, medical history and medical literature.

The association is being represented by two delegates at the Congress of the International Federation of Library Associations to be held in Madrid May 19 to 30. These delegates will return in time to report upon the congress at this meeting.

This association consists of about 175 of the medical libraries of this country and Canada, together with their librarians and a group of supporting members of physicians interested in the advancement of medical libraries.

The officers of the association are as follows: President, Charles Frankenberger, of Brooklyn, New York; Vice-President, Louise Ophüls, of San Francisco; Secretary, Frances U. A. Whitman, Boston, Massachusetts; treasurer, Mary Louise Marshall of New Orleans, Louisiana; chairman of Executive Committee, Marjorie J. Darrach of Detroit, Michigan.

All interested in the development of medical libraries are invited to attend.

The American Neisserian Medical Society.—All who are interested are cordially invited to attend the annual meeting of the American Neisserian Medical Society to be held on June 11, 1935, at the Claridge Hotel, Atlantic City, New Jersey.

As the Survey Associates, Inc. (Publishers of the Survey Graphic Magazine), See Health Insurance in California.—The California Medical Association is the first important medical group in this country—and probably the first in the world—to offer full aid and coöperation in establishing a compulsory health insurance system, according to Mary Ross, staff expert on medical economics, writing in the May issue of *Survey Graphic Magazine* (New York). "Whatever this spring's legislative action at Sacramento, the stand of the doctors marks economic and social tides which cannot long be held back," says Miss Ross. "The economic barrier between people who need medical care and doctors who need income runs like a Chinese wall through all parts of our country. . . . The partnership of sickness and poverty is nothing peculiar to California. Surveys in a widely separated group of cities showed what the California SERA study strikingly confirmed: disabling sickness is far more common among the poorer than among the better-to-do." Miss Ross says that the action of the doctors expresses "the views of the less vocal doctors who have not entered into controversies on medical policies and of many 'little men' of the profession—country doctors, men with offices above drug stores, men from hard-hit industrial and agricultural counties and middle-class city neighborhoods—who had reason to know what medical costs mean to their patients and themselves."

Aside from the fact that California had a few years ago more physicians in proportion to population than any known area in the world, thus giving rise to competition among them, Miss Ross believes that the state's eighty years of experience with various forms of organized medical service have helped to point the issue. "Probably no health insurance law has ever come into being with the benefit of as wide knowledge and basic agreement as exists in California at the present time," says Miss Ross. "California has the chance to establish a model for the whole American continent."

CORRESPONDENCE

Concerning Antivivisection Bill (A. B. 2401).

May 1, 1935.

To the Editor:—For your information I am enclosing a copy of a letter sent to assemblymen and the senator from this district.

Sincerely,

J. C. Geiger, M. D.,
Director of Public Health.

* * *

Member, California Legislature, Sacramento, California:

May I offer a protest to Assembly Bill 2401, the so-called Humane Pound Bill. This bill is one against animal experimentation.

There are two universities and one research institution that may be involved in animal experimentation for scientific purposes in San Francisco, namely, the Medical School of the University of California, Stanford University School of Medicine, and the Hooper Foundation for Medical Research of the University of California.

It is the writer's opinion that to pass this bill would grant, or serve as an excuse, to many persons, either officially or otherwise, to act as inspectors and annoy legitimate research workers by requesting, and perhaps demanding, search for certain dogs or insisting that the dogs are in the institutions. Moreover, I consider this bill entirely anti-medical, and as an individual and for the Department of Public Health, vehemently protest it. Furthermore, if anything anti-medical inimical to animal experimentation upon which much of our modern public health depends comes from a committee officially dedicated to health it would appear to be a travesty on health.

May I point out to you that animal experimentation as a means of promoting human and animal welfare has recently received the sanction of two tribunals of great importance, one in the United States and the other in England. Both decisions tend to brighten the outlook for the protection of medical science against the perpetual warfare that threatens it through bequests for the support in perpetuity of organizations opposed to experiments on animals.

In the American case (Pennsylvania Company for Insurance on Lives and Granting of Annuities, executor of the Estate of A. Sidney Logan, deceased, petitioner vs. Commissioner of Internal Revenue, respondent, 25 B. T. A.), the United States Board of Tax Appeals held that a bequest to a society organized for the "total abolition of all vivisectional experiments on animals and other experiments of a painful nature" was not a bequest to a corporation organized and operated exclusively for the prevention of cruelty to animals, and that, therefore, the amount of such a bequest could not be deducted from the principal of an estate in computing the federal estate tax. The decision of the Court of Appeals in the English case (in re Grove-Grady: In re Plowden vs. Lawrence, 98 L. J., Ch. 261 (1920), 1 Ch. 557, the Law Journal 71:329 (May 9), 1931), raised the question whether, "in the light of later knowledge in regard to the benefits accruing to mankind for vivisection," bequests designed to hinder and prevent vivisection would today be regarded as charitable bequests. On appeal, the House of Lords forbade the use for antivivisection propaganda of any part of the legacy concerning which the question was raised. The English decision is of only persuasive influence in the United States, but the changing view suggested by it with respect to bequests to create trusts to carry on activities against animal experimentation is of vital importance. Unless such trusts can be shown to be charitable in character, they cannot be made to operate in perpetuity.

The decision of the United States Board of Tax Appeals is available. It is a remarkable statement of the value of experimentation, all the more cogent because of the dispassionate, non-medical, judicial source from which it emanated. The executor of the estate against whom the decision was rendered may appeal to the courts for relief, but a decision by an appellate court would almost certainly do nothing more than strengthen the defense of animal experimentation that the decision affords.

These cases should be read by all members of your committee. Certainly the weight of the evidence proves that animal experimentation is of benefit to mankind—and to animals, too, for that matter. If animal experimentation is for the benefit of mankind and of animals, bequests and laws to hinder or prevent such experimentation obviously cannot be for the benefit of mankind, and bequests to accomplish that end cannot be charitable bequests. It may be argued that such reasoning is begging the question: that it assumes that the benefits that have been and are being derived from animal experimentation are at best not sufficient to offset the alleged cruelty to such experimentation. The answer is that there is no cruelty associated with animal experimentation that is not within the reach of the ordinary laws for the prevention of cruelty to animals. The fact that prosecutions for cruelty in connection with animal experimentation are practically unheard of, despite the vigilance of antivivisectionists, is evidence of the absence of such cruelty. The trouble with the antivivisectionists' reasoning lies in the fact that they fail to distinguish between pain and cruelty and set up their own standards of cruelty, which are not the standards of the law nor the standards of the community.

Probably these two legal decisions represent the general trend of mature and cultured thought on the subject of animal experimentation, when uninfluenced by lurid appeals to the imagination and by appeals to self interest. Both decisions were based on the orderly presentation of legal evidence, not on such clamorous, virulent, emotional speech-making as commonly fill the air when animal experimentation is discussed before legislative committees.

Sincerely,

J. C. Geiger, M. D., *Director.*

Concerning malpractice defense: correction of an error.

A Correction

In the April, 1935, issue of California and Western Medicine, page 334, there appears the printed reproduction of a letter from Dr. Horace F. Pierce to the secretary of the California Medical Association in which Doctor Pierce expresses appreciation for the services rendered in a case brought against him by one Romero by the Medical Defense Fund through W. M. Rains. This article appeared in the column headed "Correspondence," under the heading "Concerning malpractice defense rendered through the medical society of the State of California. A letter of appreciation."

Mr. W. M. Rains, who is therein referred to, is associated with Attorney W. I. Gilbert of Los Angeles, the regularly retained attorney in Los Angeles County and vicinity for the Medical Protective Company of Fort Wayne, and the successful defense of Doctor Pierce in this case was entirely in the hands of Mr. Gilbert and his associate, Mr. Rains.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 6, June 1910

From Some Editorial Notes:

Notice.—The statement has been made by sundry persons who should know better, that the accounts of the Society have never been investigated. This is absolutely untrue. Every item of income or expense has been accounted for and examined by an expert accountant, beginning in May, 1905. The books are closed on the 31st of December of each year and turned over to an expert accountant, who is employed by the Council for that purpose. . . .

* * *

Medical Defense.—The most important action of the House of Delegates at the last meeting, Sacramento, April 20, 1910, was undoubtedly the establishment of medical defense on a permanent basis. The experience of other states and our own experience since last July have shown conclusively that all members may be defended in all suits for alleged malpractice for a comparatively small sum per annum. . . .

The plan adopted is very simple; there are but three requirements. First, you must be a member in good standing, dues paid in your county society, and you must have been in good standing at the time the alleged malpractice was committed. Second, the alleged malpractice must have occurred after you became a member of the society, or after the first day of July, 1909. Third, you must send to the secretary of the State Society, within forty-eight hours after you are served in any suit, a full, true and correct copy of the complaint together with a full statement of all the facts in the case. Is there anything difficult about any of these requirements? Pay your dues and keep them paid; notify the office of the Society promptly when you are sued or a suit is threatened. That is all there is to it. You will be put to no additional expense other than your dues. . . .

* * *

Easy Money.—Schemes innumerable there are for separating money from people. One is again reminded of the historic, if unflattering, remark of a New York police inspector when he raided the establishment of a notorious "sure-thing operator": "Preachers, doctors, and lawyers are the easiest suckers there are." . . .

James H. Parkinson, M. D., President, 1909-1910.—President Parkinson was born in Dalkey, County Dublin, Ireland, October 28, 1859, his father being Henry Parkinson, barrister-at-law, and his mother, Henrietta Flood. Both his grandfathers were physicians, and one granduncle, whose name is usually associated with Flood's interarticular ligament of the shoulder joint. He received his education at private schools, passing the entrance examination of the Royal College of Surgeons, Ireland, from Kingstown school. . . .

In 1887 Doctor Parkinson founded the *Sacramento,* later the *Occidental Medical Times,* and continued as its editor until it ceased publication in 1904. Doctor Parkinson was elected president of the State Society in April, 1909, and presided at the sessions at Sacramento, April, 1910.

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, Page 14)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

"Following anti-foreign manifestations of five thousand French students in the Latin Quarter, the Chamber of Deputies is discussing a bill providing that naturalized foreigners cannot practice as doctors in France until ten years after their naturalization. However, those having done important military service in the French Army, and also students duly inscribed at the date the law is promulgated, may be exempted from this restriction." (Press dispatch, dated Paris, April 20, and printed in the San Francisco *Examiner,* April 21, 1935.)

"While members mimicked the barks of dogs, the Assembly yesterday refused to bring from the Public Health and Quarantine Committee a bill by Assemblyman Charles J. Wagner, designed to protect dogs from vivisection. Only seventeen members voted to bring the measure to the floor, with fifty-four opposing. . . . The committee tabled the bill when physicians and dentists urged its defeat on the ground it is an anti-vivisection measure in disguise. They argued an anti-vivisection act would prevent medical science from performing experiments necessary for the health of the human race." (Sacramento *Bee,* May 11, 1935.)

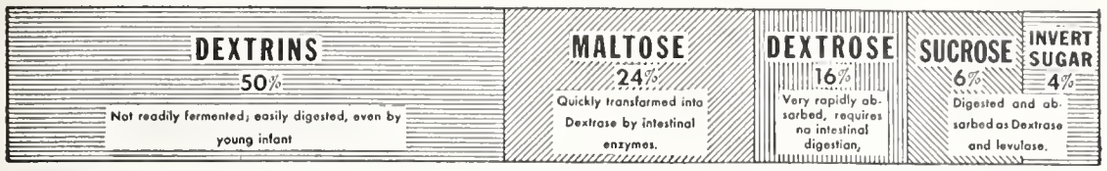
"Testimony of a bevy of pretty girls and a 'fashion show' which failed to have its première resulted in the conviction of F. J. Miller, self-styled doctor and radio artist on petty theft charges in Police Judge Chris B. Fox's court yesterday. He will be sentenced on Monday. According to police, Miller advertised for models to work in a 'fashion show' he was promoting. Seventy-five girls applied. Among them was Ann Pendleton. Miller, she said, offered her the job of 'show manager,' then he requested payment of a $20 bond. She paid the money. Marie Haug was offered a position of 'secretary,' with the proviso that a $50 bond be paid. Lorraine Colbert . . . said Miller demanded a $2.50 bond. Police declared Miller asked for similar payments from other applicants. . . . According to Los Angeles police, Miller served a 180-day jail term there for alleged violation of the State Medical Practice Act. They declared he exhibited papers to show that he was the highly publicized 'Brother Jack' of Aimee Semple McPherson's Angelus Temple radio station. Miller told Oakland police he was a doctor who was graduated from a Vienna University in 1912." (Oakland *Tribune,* April 26, 1935.) (Previous entries, July, 1933, advertising page 21.) According to the California State Division of Criminal Identification and Investigation, he is listed as "Dr. Frank J. Mills, alias Dr. Frank H. B. Miller; Franklin J. Miller, Frank Joseph Miller; Los Angeles, No. 30693-M-11; San Diego, No. 9949-A."

"Walter Beck, Pismo Beach masseur, was found not guilty of violating State medical laws when he was tried before a jury in Justice of Peace L. C. Routzahn's court at Arroyo Grande Thursday. . . ." (San Luis Obispo *Telegram,* April 19, 1935.)

"Dr. Charles O. Long, formerly a physician and surgeon in Calapatria, was arrested in Phoenix Sunday on a narcotic charge and is being held in jail there

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

(Continued in Front Advertising Section, Page 20)



• COMPOSITION OF KARO •

Intestinal fermentation is kept at a low level when Karo *is fed*

The dextrose and maltose components are quickly absorbed and the difficultly fermentable dextrin is gradually and completely transformed into the simple monosaccharides . . . When *Karo* supplies the added carbohydrate in infant feeding formulas, the flooding of the intestinal tract with excessive amounts of easily fermentable sugars is avoided.

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Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

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SAN FRANCISCO

A Limited General Hospital of 200 Beds

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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Intern Training.

Limited Facilities for Part-Pay Treatment

PROFESSIONAL PROTECTION

SINCE 1899 SPECIALIZED SERVICE

A DOCTOR SAYS:

"The thoroughness with which the case was prepared was not only a revelation to me but a great consolation. The efficiency of your legal department is of the highest order. Every minute detail was thoroughly covered regardless of the time and expense involved."

THE MEDICAL PROTECTIVE COMPANY

OF FORT WAYNE, INDIANA

WHEATON, ILLINOIS

The British Medical Association and the Attempt of the Osteopaths to Obtain Registration.—The second reading in the house of lords of the bill for the registration and regulation of osteopaths was reported in a previous letter. A special committee of the council of the British Medical Association is preparing a memorandum on osteopathy, and the medical secretary has prepared the following preliminary criticism: If the bill becomes law, two different classes of practitioners recognized under different acts will be set up. The purpose of the medical acts now in existence was to draw a clear line between persons who have and persons who have not passed through the authorized medical curriculum. This will be defeated. The student of osteopathy, after a course of instruction of considerably less duration than the medical student, will be admitted to the register of osteopaths and entitled to hold himself out to practice in the wide field of medicine. A new type of practitioner will appear and the public will have to distinguish for itself between those who have satisfied the full requirements of the General Medical Council, those who have satisfied the lesser and different requirements of the Board of Registration of Osteopaths, and those who have received no recognized training at all. Today any physician is free to practice any form of treatment which he regards as beneficial. Neither belief in osteopathy nor the practicing of it can exclude anyone from the Medical Register. The General Medical Council, which controls practice, is expressly prohibited from making any distinction between practitioners following different theories or methods of treatment. Those who have a knowledge of the human body in health and disease sufficient to justify them in engaging in medical practice can satisfy the requirements of the General Medical Council and then adopt what methods they like.

Of the "osteopathy" which the bill is to recognize, little information is given by those claiming registration. It is described as "a system of treatment by



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manipulation methods." Yet in clause 8 of the bill it is laid down that no one unless registered under this act shall practice osteopathy. The course of instruction is shorter than that demanded of the medical student. The effect of this would be to attract a new and inferior type of student. Yet on admission to the register he will hold himself out as qualified to practice practically the whole field of medicine. Such a register will prove a back door to medicine. Is this in the public interest? As the law stands, the public can seek its treatment where it likes, with the Medical Registrar to enable it to distinguish those who have satisfied minimum standards. Soon there will be demands from other cults, and registers will multiply. The bill precludes anyone not registered as an osteopath from practicing osteopathy, which is described merely as a system of manipulative treatment. It follows that physicians are to be prevented from using manipulative treatment. No monopoly of any particular system of treatment should be created. According to the bill the proposed board of registration will consist of a chairman appointed by the privy council, two persons representative of science, not being physicians, appointed by the ministry of health, and eight osteopaths, five of whom are to be appointed by the British Osteopathic Association. How can a board thus created have an intimate acquaintance with medical science? Medical education must rest on a broad scientific foundation, so that the student may be both competent in practice and trained to judge the value, or want of value, of future developments. Such a training cannot be provided in institutions restricted to a particular theory.

Speaking at the annual dinner of the Medico-Legal Society, Lord Horder made some crucial objections to the proposed registration. It was difficult for him to conceive how it was possible to erect a single therapeutic measure into a system of medicine, to eliminate the art of diagnosis and the basis of all medicine, which was pathology, and proceed straight to treatment. He wondered what was going to happen to the British public if for diagnosis and the pathology that underlay diagnosis there was substituted one single treatment, however important, and if the man who had this one method of treatment at his command was to be elevated to the position of a registered medical practitioner. Still, if the public wanted it, let it be tried out. He did not think that physicians should protest too much against that sort of thing. The more they protested the more would osteopaths consider themselves martyrs, and martyrdom was valuable propaganda. — London News Letter, *Journal of the American Medical Association.*

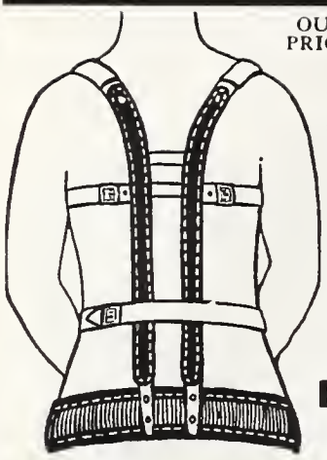
Adolescence Favorable to Eye Healthfulness.—"The period between the ages of fifteen and twenty is, in itself, favorable to the healthfulness of the eyes as a whole," comments Dr. Hyman Cohen in an article on "Eye Diseases During Adolescence." When the eyes have been safeguarded by examination and when refractional errors have been corrected, the eyes are likely to continue free from disease into the adult period, although abuses and misfortunes may await them there.

Former eye troubles, such as the various kinds of conjunctivitis, may carry over and reappear; interstitial keratitis, an inflammation of the cornea of syphilitic origin, may last far into this period. When there have been inflammation and irritation through infection and uncorrected sight defects, the foundation for further trouble is laid, and its occurrence is frequent.

The True Economy of Dextri-Maltose.—It is interesting to note that a fair average of the length of time an infant receives Dextri-Maltose (Mead) is five months: That these five months are the most critical of the baby's life: That the difference in cost to the mother between Dextri-Maltose and the very cheapest carbohydrate, at most is only $6 for this entire

(Continued on Next Page)

OTHERS ASK UP TO $50.00
TAYLOR SPINAL BRACE



OUR PRICE **$20.00**

A well padded surgical steel spinal support furnished with apron and perineal straps.

Made to order in 24 hours

Take measurements around iliac crest, umbilicus, distance from sacro lumbar articulation to 7th cervical vertebra prominence.

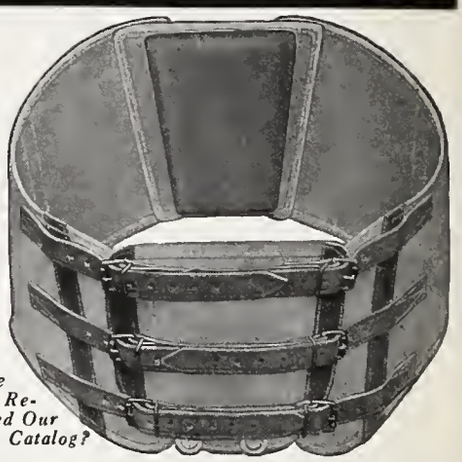
THIS HIGH GRADE
OTHERS ASK UP TO $10.00
SACRO-ILIAC BELT
OUR PRICE **$3.50**

Beautifully made of six inch orthopedic webbing, well reinforced, supplied with perineal straps.

Take measurements around the hips three inches below the iliac crest.

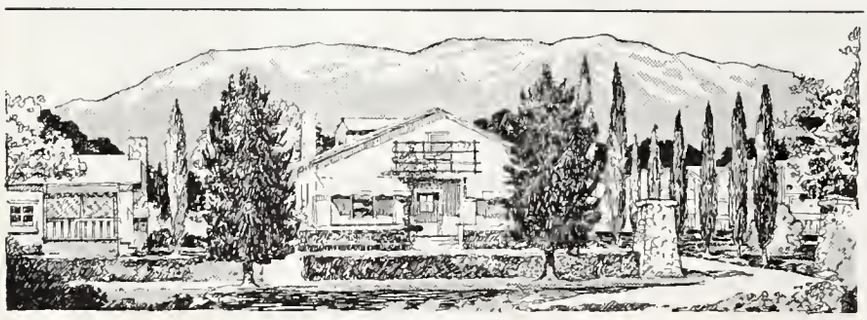
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Has established and maintained a reputation, both among physicians and patients, for service and satisfaction.

Doctor: Send your next patient here, and you may feel assured not only that he will receive maximum benefit from his sojourn, but he will be grateful and will thank you for sending him to

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BELMONT, CALIFORNIA
INTERNAL MEDICINE AND SELECTED NEUROPSYCHIATRIC CASES
CLARE MEHRTENS, *Director* WILL REBEC, M. D., *Medical Director*

Number of Patients Limited	*Accredited to* AMERICAN MEDICAL ASSOCIATION	*Telephone* BELMONT 111

(Continued from Preceding Page)

period—a few cents a day: That, in the end, it costs the mother less to employ regular medical attendance for her baby than to attempt to do her own feeding, which in numerous cases leads to a seriously sick baby eventually requiring the most costly medical attendance.

Regulations Governing Use of Sewage for Crop Irrigation Purposes.*—Rule 1. *Raw Sewage.* Raw, *i. e.*, untreated, sewage containing human excrement shall not be used for irrigating growing crops. Use of bar screens, grit, or detritus tanks is not to be considered as sewage treatment under these regulations.

Rule 2. *Raw or Undigested Sludge.* No sludge or screenings shall be distributed or used for fertilizing any growing vegetables, garden truck or low growing fruits or berries, unless the sludge or screenings shall have been rendered innocuous and free of danger of spreading disease by such measures as (*a*) kiln drying, (*b*) bed drying or ageing in storage, and in either case for not less than thirty days, (*c*) conditioning or treating to the satisfaction of the State Department of Public Health, (*d*) digestion to a point where the sludge or screenings are practically odorless, drains readily and not over 50 per cent of the total solid matter is in the volatile form.

Rule 3. *Settled or Undisinfected Sewage Effluents.* Effluents of septic tanks, Imhoff tanks or of other settling tanks, or partially disinfected effluents of sprinkling filters or activated sludge plants or similar sewages, shall not be used to water any growing vegetables, garden truck, berries, or low-growing fruits such that the fruit is in contact with the ground, or to water vineyards or orchard crops during seasons in which the windfalls or fruit lie on the ground. Such sewage, effluents or any sludge or screenings shall not

* Adopted by the California State Department of Public Health May 27, 1933, under the provisions of the Public Health Act, and General Law.

* Note.—Attention is called to the fact that the disposal of sewage, sewage effluent or sludge for irrigation or fertilizing purposes requires the holding of permit therefor, issued by the State Board of Public Health under the Public Health Act, to the city, town, district, firm or person owning or operating the sewer system. Users of the sewage, effluent or sludge are, however, liable as agents, for the violation of such permit or the Public Health Act. Sale or disposal of any crop dangerous to the public health is subject to various other state health laws. Rules governing the crops which may or may not be watered or fertilized by sewage, effluent or sludge, are shown.

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be permitted in ditches or pipes which may be used to irrigate vegetables, garden truck, berries, or low-growing fruit.

Nursery stock, cotton, and such field crops as hay, grain, rice, alfalfa, fodder corn, cowbeets, and fodder carrots may be watered with such settled or undisinfected or partially disinfected sewage effluents provided that no milch cows are pastured on the land while it is moist with sewage, or have access to ditches carrying such sewage.

Rule 4. *Oxidized Effluent Highly Disinfected or Otherwise Treated for Bacterial Removal.* The foregoing restrictions do not apply against the use of well oxidized nonputrescible, and reliably disinfected or filtered effluents which always meet the following bacterial standard: in any twenty consecutive samples, from which five ten-cubic centimeter portions each are examined, not over ten portions shall be positive for members of the Coli-aerogenes group, and in no single sample shall over half the .1 cubic centimeter portions of the sample of the effluent be positive for the above organisms. Samples shall be analyzed according to the latest Standard Methods of Examination of Water and Sewage of American Public Health Association.

The works and methods used for the production of such oxidized and disinfected effluent must be correctly adapted to the purpose and designed with adequate factors of safety to produce uniformly a well-oxidized, odorless and inoffensive effluent, thoroughly filtered, treated or disinfected to meet the above standard.

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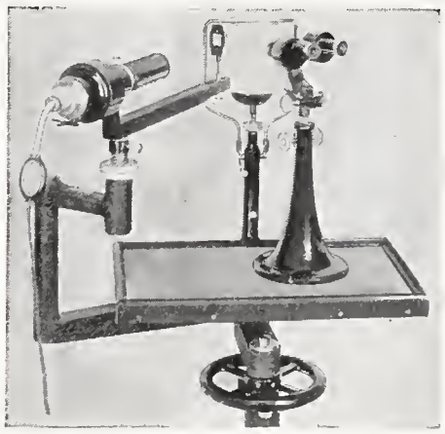
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For example, where disinfection is employed, apparatus and equipment for applying disinfecting agent or agents shall be in duplicate throughout, including machines, weighing scales and reserve supply of disinfectant for each machine. The disinfecting agent or agents shall be kept in separate rooms from the metering mechanism to prevent corrosion thereof. Each room shall be provided with a suitable source of heat so as to prevent interruptions of the disinfection in cold weather. Sewage flow shall be measured and flow of the disinfectant regulated to provide

(Continued on Next Page)



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an adequate dose of disinfectant at all times. The feed of disinfectant shall provide an excess over actual needs and be divided between two or more metering machines so that interruption in the action of one will still yield the bacterial results prescribed. Appropriate laboratory tests to show that the disinfection is adequate shall be made at frequent intervals and at least twice daily. For such routine bacterial control negative twenty-four-hour presumptive tests for the Coli-aerogenes group in the prescribed dilutions will be recognized as sufficient in the absence of other evidence that the presumptive test is insufficient. Proper records shall be kept of actual operations and results. In short, precautions shall be of an order fully equal to those taken by cities using reliable, modern methods of disinfecting water, obtained from a contaminated source of supply.

Rule 5. *Cross Connections.* No cross connections shall be permitted between any pipe line or works which may contain sewage, sewage effluent or sludge in any pipe line or works to be used for domestic water supply or drinking purposes. Signs warning that the water is not a drinking water should be placed on pipes at ditches, faucets, etc., that may contain any sewage effluent, sewage or sludge.—

Alcohol Neither Prevents Nor Cures Pneumonia.—"To avoid pneumonia, keep fit by temperance in food and drink, wear ample clothing, have sufficient sleep, be moderate in work and pleasure, and avoid those who are ill with the disease," Dr. Jesse G. M. Bullowa advises in an article on "Pneumonia."

If colds are acquired, they should be treated by a physician. If a chest cold develops, proper treatment may prevent the development of pneumonia in case one encounters the germs that cause pneumonia or in case one is already carrying them in the nose or throat or sinuses. When one becomes chilled or wet or cold, a hot bath and a drink of warm broth will restore body heat. Whisky and gin do not accomplish this; they cause a feeling of internal warmth, but they dilate the capillaries of the skin and thus cause a further loss of heat while producing a feeling of warmth and a false sense of benefit. Alcohol lowers resistance to pneumonia and has no place in the prevention of pneumonia or in increasing resistance to it.

The Cost of Health Insurance in 1933.—The expenditures of the municipal krankenkassen during the year 1933 have just been made public. The status of the krankenkassen as such has already been reported. The total expenditures (inclusive of losses incurred by the disposal of property and by other disbursements) of the municipal krankenkassen reached during 1933 the total of only 676.6 million RM compared to 713.2 million RM in the preceding year. In apportioning the total expenditures for 1933 to each member the sum is 59.84 RM, compared to 60.80 RM in 1932. The greatest portion of the total expenditures (79.6 per cent) was disbursed for sick benefit to the insured and their families. The average expenditure for sick benefit for each member and his family was 47.63 RM. Of this amount the disbursement for medical and dental services was 18.72 RM, for medicines 6.80 RM, for hospitalization and other nursing care 10.50 RM, and for sick pay, household and other expenditures, 11.60 RM.

The expenditures for the care of puerperal women amounted to 43.2 million RM in all; that is, to 6.4 per cent of the total disbursements. During 1932, 51.4 million RM was expended for this purpose. The disbursements for burial expenses amounted to 4.7 million RM during 1933. The costs of administration were 82.8 million RM in 1933 compared to 89.5 million RM in 1932; for each member these expenses have been decreased from 7.62 to 7.32 RM. The administration

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expenditures amounted to 12.2 per cent of the total disbursements and to 12.8 per cent of the income from premiums.

Within the scope of the benefits to the insured and the members of their families, the treatment by licensed physicians (inclusive of services in kind and of transportation costs) called for 25.3 per cent of the income from premiums during the year 1933; 7.1 per cent of the income from premiums was expended for dental care, 10.5 per cent for medicine, 17 per cent for care in hospitals (exclusive of sojourns in spas) and 19.3 per cent for sick pay in cash.—Berlin News Letter.

Faulty Posture Is Cause of Many Mysterious Ills.—"Many of life's mysterious ailments can be traced directly to stoop, slump, and bad habits of sitting" is the belief of Dr. Philip Lewin, who writes on posture. To correct bad posture, Doctor Lewin prescribes that the person with bad posture must learn to stand tall, sit tall, lie tall, and think tall. He should learn to walk with the chest thrown forward, the abdomen drawn in, the lumbar curve flattened, the shoulders well back and relaxed, and the head upward so that he looks out of the center of his eyes; the chin is not thrust forward.

While postural considerations are important in occupational, artistic and athletic activities, it has been stated that for every case of bad posture due to these causes, there are from ten to twenty persons who have acquired bad posture primarily because they sat for years in posturally incorrect school seats, thereby acquiring poor habits of posture which persisted through life.

A vicious circle is established by the reciprocal action of eyestrain and bad posture. Disturbances of eyes produce postural defects, and postural defects predispose to eye lesions. Eyestrain produces mental and physical fatigue.



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4. The climate of Colfax enables the patient to take the cure without discomfort twelve months in the year. We believe climate is secondary to medical supervision and rest, but the fact remains that it is easier to "cure" under good climatic conditions than where these climatic conditions are absent.

5. Colfax is accessible. It is on the main line of the Ogden Route of the Southern Pacific R. R. and has excellent train service. It can be reached by paved highway, being on the Victory Highway, with paved roads all the way to Colfax.

For further information address

ROBERT A. PEERS, M. D., *Medical Director*

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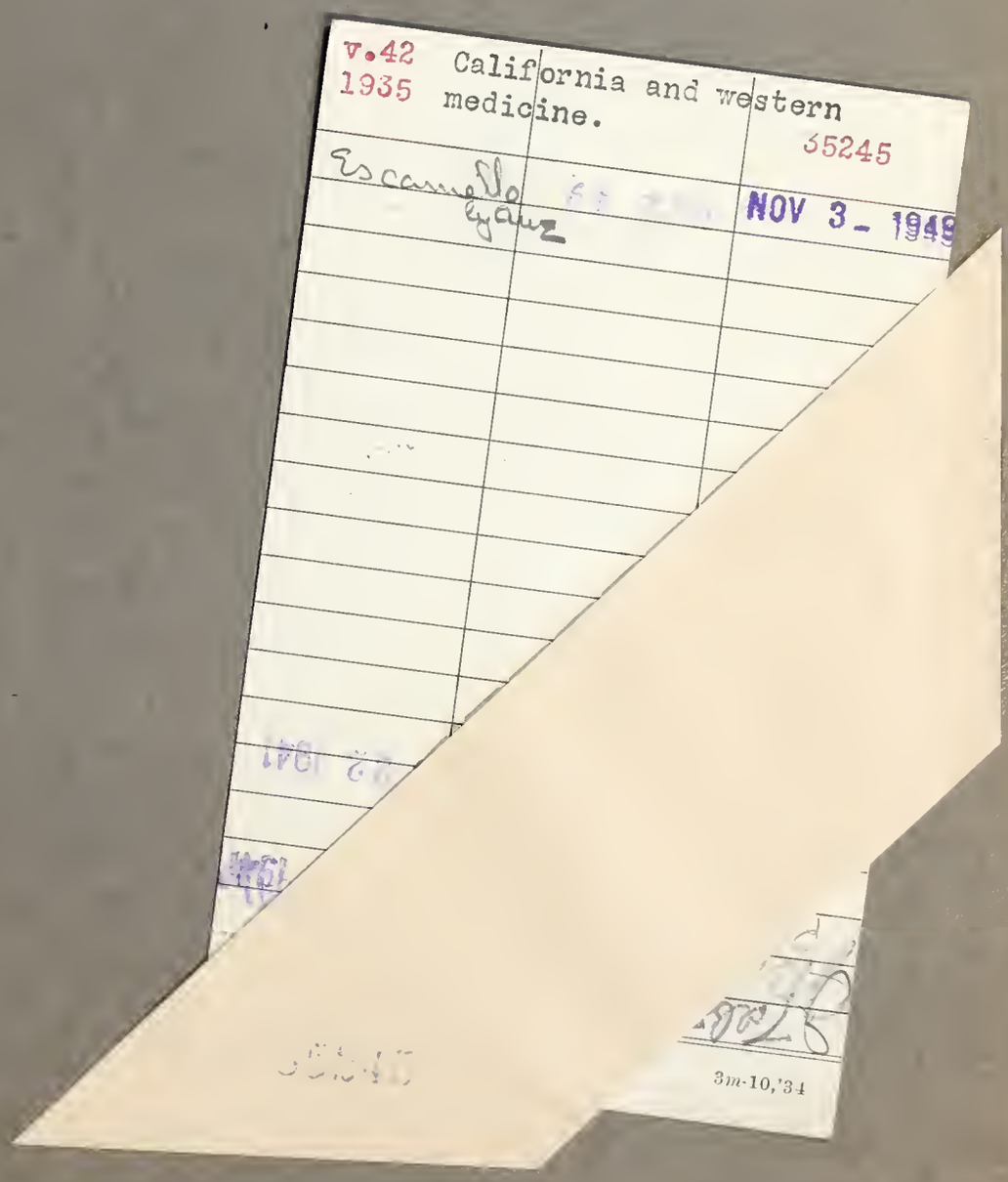
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